No. 99-1786-CFX Title: Great-West Life & Annuity Insurance Company, et al., Petitioners
v.
Janette Knudson, et vir

Docketed:
May 10, 2000 Court: United States Court of Appeals for the Ninth Circuit

Entry	Date	Proceedings and Orders
	May 9 2000	Petition for writ of certiorari filed. (Response due June 9, 2000)
	Jun 8 2000	Motion of Central States, SE and SW Areas Health and Welfare Fund for leave to file a brief as amicus curiae filed.
	Jun 8 2000	Motion of Self-Insurance Institute of America, Inc. for leave to file a brief as amicus curiae filed.
	Jun 9 2000	Brief of respondent Janette Knudson in opposition filed.
	Jun 21 2000	DISTRIBUTED for Conference of September 25, 2000
	Sep 22 2000	Supplemental brief of petitioners Great-West Life and Annuity Insurance, et al. filed.
	Nov 1 2000	REDISTRIBUTED for Conference of November 22, 2000
	Jan 2 2001	REDISTRIBUTED for Conference of January 5, 2001
	Jan 8 2001	REDISTRIBUTED for Conference of January 12, 2001
	Jan 16 2001	REDISTRIBUTED for Conference of January 19, 2001
	Jan 22 2001	Motion of Central States, SE and SW Areas Health and Welfare Fund for leave to file a brief as amicus curiae GRANTED.
	Jan 22 2001	Motion of Self-Insurance Institute of America, Inc. for leave to file a brief as amicus curiae GRANTED.
	Jan 22 2001	Petition GRANTED. limited to Question 1 presented by the petition. SET FOR ARGUMENT October 1, 2001. **********
	Feb 6 2001	Letter from respondents suggesting that writ was improvidently granted received.
	Feb 13 2001	Response by petitioners to respondents letter filed.
	Feb 16 2001	Order extending time to file the joint appendix and petitioners' brief on the merits thirty days from the date of the Court order on respondents' motion to dismiss the petition as improvidently granted.
	Feb 22 2001	Motion of respondents to dismiss the writ of certiorari as improvidently granted filed.
	Feb 28 2001	Motion DISTRIBUTED. March 16, 2001 (page 17)
	Mar 5 2001	Opposition of petitioners to motion of respondents filed.
	Mar 12 2001	Letter from the Solicitor General received and distributed.
	Mar 19 2001	Motion of respondents to dismiss the writ of certiorari as improvidently granted DENIED. Richard G. Taranto, Esquire, of Washington, D.C., is invited to brief and argue this case, as amicus curiae, in support of the judgment below.
	Mar 19 2001	Joint appendix and petitioners' brief on the merits are due on or before April 18, 2001.
	Mar 29 2001	Order further extending time to file the joint appendix

3 pp

Entry	Date	Proceedings and Orders
		and petitioners' brief on the merits to and including May 3, 2001.
	Apr 20 2001	Order extending time to file the amicus curiae brief on the merits in support of the judgment below and respondents' brief on the merits to and including June 29, 2001.
	Apr 30 2001	Motion of Self-Insurance Institute of America, Inc. (SHA) for leave to file a brief as amicus curiae filed.
	May 1 2001	Motion of National Association of Subrogation Professionals, Inc., for leave to file a brief as amicus curiae filed.
	May 3 2001	Order further extending time to file petitioners' brief on the merits to and including May 10, 2001.
	May 3 2001	Motion of AARP, et al. for leave to file a brief as amici curiae filed.
	May 3 2001	Motion of American Association of Health Plans, et al. for leave to file a brief as amici curiae filed.
	May 3 2001	Motion of Central States, Southeast and Southwest Areas Health and Welfare Fund for leave to file a brief as amicus curiae filed.
	May 10 2001	Motions of Self-Insurance Institute for leave to file a brief as amicus curiae DISTRIBUTED. Motion of AARP, et al. for leave to file a brief as amicus curiae DISTRIBUTED. Motion of Central States, Southeast and Southwest Areas Health and Welfare Fund for leave to file a brief as amicus curiae DISTRIBUTED. Motion of American Association of Health Plans, et al. for leave to file a brief as amicus curiae DISTRIBUTED. Motion of National Association of Subrogation Professionals, Inc. for leave to file a brief as amicus curiae DISTRIBUTED.
	May 10 2001	Joint appendix filed.
	May 10 2001	Brief of petitioners Great-West Life and Annuity Insurance Co., et al. filed.
	May 10 2001	Brief amicus curiae of United States filed.
	May 14 2001	Motion of Self-Insurance Institute of America, Inc. (SHA) for leave to file a brief as amicus curiae GRANTED.
	May 14 2001	Motion of National Association of Subrogation Professionals, Inc., for leave to file a brief as amicus curiae GRANTED.
	May 14 2001	Motion of AARP, et al. for leave to file a brief as amici curiae GRANTED.
	May 14 2001	Motion of American Association of Health Plans, et al. for leave to file a brief as amici curiae GRANTED.
	May 14 2001	Motion of Central States, Southeast and Southwest Areas Health and Welfare Fund for leave to file a brief as amicus curiae GRANTED.
	Jun 29 2001	Motion of Maryland HMO Subrogation Plaintiffs for leave to file a brief as amici curiae filed.
	Jun 29 2001	Brief of respondent Janette Knudson filed.
	Jun 29 2001	Brief amicus curiae of Richard Taranto in support of judgement below filed.
	Jul 13 2001	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Jul 18 2001	Record filed.
	Jul 25 2001	CIRCULATED.
	Aug 1 2001	Reply brief of petitioner Great-West Life and Annuity Insurance Co., et al. filed.
	Sep 7 2001	Motion of Maryland HMO Subrogation Plaintiffs for leave to file a brief as amici curiae GRANTED.
	Sep 7 2001	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Sep 10 2001	Motion of respondents for leave to participate in oral argument and for divided argument filed.
	Sep 24 2001	Motion of respondent for leave to participate in oral argument and for divided argument DISTRIBUTED.
	Sep 25 2001	Motion of respondents for leave to participate in oral argument and for divided argument DENIED.
	Oct 1 2001	ARGUED.

No. 99-1786-CFX

Supreme Court, U.S.
FILED
991786 MAY 9 2000
OFFICE OF THE CLERK

No. _____

In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

THOMAS H. LAWRENCE
Counsel of Record
LEWIS FISHER HENDERSON
& CLAXTON, LLP
5050 Poplar Ave., Ste. 1717
Memphis, Tennessee 38157
(901) 767-6160

57 pp

QUESTIONS PRESENTED FOR REVIEW

1. This Court previously held in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), that "equitable relief," as used in 29 U.S.C. § 1132(a)(3), means those types of relief that were "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." The Ninth Circuit held that enforcing a recoupment of benefits provision in a health plan violates this prohibition against seeking "compensatory damages" simply because recouping benefit payments involves a monetary payment. The Court therefore held that federal courts lack subject matter jurisdiction over actions brought by ERISA plan fiduciaries to enforce recoupment provisions. Did the Court err?

2. A court may not award attorney's fees under a federal statute unless the court has subject matter jurisdiction under that statute. The Ninth Circuit affirmed the district court's award of attorney's fees under ERISA to Respondent Janette Knudson despite the fact that the Ninth Circuit held that subject matter jurisdiction did not exist under ERISA. Did the Court err?

LIST OF PARTIES

The caption of the case in this Court contains the names of all the parties. There are no parent or publicly held companies that own 10% or more of the Petitioners' stock.

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OPINIONS BELOW

This action was initiated by Petitioners in the United States District Court for the Central District of California, and that court entered summary judgment in favor of Respondent Janette Knudson. The order granting Respondent's motion for summary judgment is reprinted in Appendix B.[1] There is no official citation to that order. The Petitioners moved for reconsideration of that order and Respondent Knudson moved for an award of attorney's fees under ERISA. The district court granted Knudson's motion for attorney's fees and denied Petitioners' motion for reconsideration. The order disposing of these motions is reprinted in Appendix C.

Petitioners appealed to the United States Court of Appeals for the Ninth Circuit, case number 98-56472, and that Court entered an opinion on February 7, 2000. The opinion is reprinted in Appendix D. The citation for the opinion is *Great-West Life & Annuity Insurance Company, et al. v. Knudson,* No. 98-56472, 2000 WL 145374 (9th Cir. Feb. 7, 2000).

Respondent Janette Knudson moved for attorney's fees under ERISA, and Petitioners filed a Suggestion for Rehearing *En Banc*. On March 22, 2000, the Ninth Circuit

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[1] The district court's order granting Respondent's motion for summary judgment should be read in conjunction with the district court's previous order granting Respondent's motion to remand a related state court action that was previously removed to federal court and, *sua sponte,* remanded to state court. Therefore, the district court's remand order is reprinted in Appendix A. There is no official citation to that order.

denied the Suggestion for Rehearing *En Banc*. On April 3, 2000, the Court denied Respondent Knudson's motion for attorney's fees under ERISA.

BASIS FOR JURISDICTION IN THIS COURT

This action was filed in the United States District Court for the Central District of California. The court entered summary judgment in favor of Respondent Knudson. Petitioners timely appealed to the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit entered its opinion on February 7, 2000. Petitioners filed a Suggestion for Rehearing *En Banc*, which was denied on March 22, 2000.

This petition is timely filed under Supreme Court Rule 13(1), and this Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

Pursuant to Supreme Court Rule 14(e), Petitioner provides the following specific information:

(i) Date the judgment or order sought to be reviewed was entered:

February 7, 2000, the date of the Ninth Circuit's opinion

(ii) Date of any order respecting rehearing/extension of time:

The Ninth Circuit denied Petitioner's Suggestion for Rehearing *En Banc* on March 22, 2000

(iii) Rule 12.5 considerations:

Not applicable to this Petition

(iv) Statutory provision conferring jurisdiction:

28 U.S.C. § 1254(1)

(v) Rule 29.4 statement:

Not applicable

CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES, AND REGULATIONS INVOLVED

29 U.S.C. § 1132(a)(3):

(a) Persons empowered to bring a civil action

A civil action may be brought –

* * *

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan....

29 U.S.C. § 1132(g):

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

STATEMENT OF THE CASE

Janette Knudson and Eric Knudson were covered persons under the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. Ms. Knudson was injured in an automobile accident. The Plan paid benefits to Ms. Knudson and/or her medical providers in the amount of $411,157.11 for her medical care. In 1993, Ms. Knudson sued the third parties allegedly responsible for her injuries in California Superior Court.

This case involves the interpretation of a specific Right of Recovery provision of the Plan, which entitles Earth Systems to recoup the benefits paid on behalf of Knudson if she recovers from third parties. That section of the Plan provides:

> A third party may be liable or legally responsible for expenses incurred by a covered person for an illness; or a sickness; or a bodily injury.
>
> When this happens we will, subject to all other terms and provisions of this booklet, pay any benefits which are payable for the expenses incurred by the covered person for the treatment of such illness, sickness or

> bodily injury (the loss).
>
> RIGHT OF RECOVERY. We will, at our sole option, have the right to recover from the covered person any payment for benefits paid for treatment of such loss under this booklet which the covered person is entitled to receive from a third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the covered person receives from:
>
> > The third party;
> > or the third party's insurer or guarantor; or the covered person's uninsured motorists insurance.
>
> This lien will not exceed:
>
> > the amount of benefits paid under this booklet for the treatment of a loss; or
> >
> > the amount received by the covered person for such medical treatment from the third party.
>
> CONDITIONS:
>
> > The covered person must cooperate fully with us in asserting our right to recover. If the covered person: – makes any recovery as set forth in

this provision; and – fails to reimburse us fully for any benefits paid under this provision; then he will be personally liable to us the extent of such recovery up to the amount of the first lien.

Before any benefits are paid for the treatment of such loss under this booklet, we may require the covered person to provide all information and sign and return all documents necessary to exercise our rights under this provision.

After Ms. Knudson was injured, her husband signed a Right of Recovery Agreement on behalf of his capacitated spouse, which states:

> As a member of the above named Plan, I have made a claim for covered medical expenses under the terms of the Plan for myself or dependent for the injury/illness detailed above.
>
> * * *
>
> I request that benefits be paid at this time without the necessity of awaiting final determination of responsibility. . . .
>
> * * *
>
> I also understand that under the terms of the Plan, the Plan may recover from me any

> payments for benefits paid under this Plan for which I or my dependents may be entitled to receive from a third party. The Plan shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise, that I or my dependant receives from another party, the other party's insurer or guarantor, or my own insurer or guarantor. Said first lien shall be for the amount of medical and hospital benefits paid by the Plan, I shall be personally liable to the Plan to the extent of such recovery up to the amount of its first lien. I agree to cooperate fully with the Plan in asserting its rights to recover.

After the Knudsons acknowledged their obligations, Earth Systems paid $411,157.11 in benefits on Ms. Knudson's behalf. If Eric Knudson had not signed the Right of Recovery Agreement, it was undisputed below that Knudson would not have received payment for her medical treatment.

As Knudson's third-party action progressed, her counsel and a representative of Great-West Life & Annuity Insurance Company,[2] Louis Tuccitto, discussed resolution of Petitioners' right of recoupment. Knudson's counsel was sent, on February 7, 1994, a copy of the Summary Plan Description containing the Right of Recovery provision. Knudson's counsel sent Great-West a letter on September 29, 1995, acknowledging Earth Systems' recovery rights: "This letter will acknowledge your lien in the amount of

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[2] Great-West is the third-party administrator for the Plan.

$411,157.11. . . ."

Despite this acknowledgment, Knudson's attorney sought a compromise of the lien. After learning from Knudson's attorney that Knudson was recovering $650,000 because of her injuries, Petitioners offered to reduce their lien by accepting $200,000 instead of $411,157.11, with Knudson's counsel accepting $200,000 as an attorney's fee, and the remaining $250,000 being paid to Knudson. Knudson's attorney refused.[3]

On March 27, 1997, after these efforts at compromise failed (and despite the previous "acknowledgments" by Knudson and her counsel), Knudson mailed to Great-West a motion to approve settlement in her third-party action, which was pending in California Superior Court. Knudson, however, did not serve Great-West (or Earth Systems) with a summons in that action. On April 22, 1997, Great-West removed to the United States District Court for the Central District of California the claims asserted against it based upon 28 U.S.C. § 1445(c) and the complete preemption doctrine under ERISA. On June 30, 1997, the district court *sua sponte* remanded those claims to state court because the court held that Great-West was not a party in the state court action.

On July 7, 1997, Petitioners filed the present action and served Ms. Knudson and her attorney. On July 9, 1997, the district court denied, based upon the Anti-Injunction Act, Petitioners' application for temporary restraining order.

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[3] Ultimately, Knudson's attorney received $373,426.00 of the $650,000.00 settlement.

On July 23, 1997, the California Superior Court approved the settlement of Knudson's state court action against the third parties allegedly responsible for her injuries. In that settlement, Knudson and her attorney collaborated with the state court defendants and agreed that Earth Systems' reimbursement amount of $411,157.11 was worth only $13,828.70. The settlement negotiated by the parties to the state court action allocated by agreement only $13,828.70 of the $650,000.00 settlement to past medical expenses. This agreement was reached despite the fact that Knudson, through her counsel, had previously acknowledged in writing that Earth Systems' lien based upon medical expenses was actually $411,157.11. Earth Systems (and the other Petitioners) were not parties to – and did not participate in – the state court action.

In December, 1997, Petitioners moved for summary judgment, moved for leave to file their Second Amended Complaint to add Jeffrey S. Pop and his law firm and Louise Curinga, Trustee of the Special Needs Trust, as defendants, and moved for preliminary injunction against the new parties. Knudson filed her cross-motion for summary judgment.

On May 20, 1998, the district court granted Knudson's motion for summary judgment and denied Petitioners' motion for summary judgment. Petitioners filed a motion for reconsideration. On July 10, 1998, the district court denied Petitioners' motion for reconsideration and granted Knudson's motion for attorneys' fees.

ARGUMENT FOR GRANTING THE WRIT

I. The Court should grant the petition to resolve a conflict among the federal courts of appeals and a decision of this Court over whether enforcing a recoupment provision in a health plan constitutes "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3).

A. The federal courts of appeals are split over whether enforcing a recoupment provision in a health plan constitutes "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3).

In reaching its decision in this case, the Ninth Circuit relied entirely upon its earlier decision in *FMC Medical Plan v. Owens*,[4] which ruled that federal courts do not have subject matter jurisdiction over 29 U.S.C. § 1132(a)(3) claims whenever the substance of the remedy is monetary. The decisions in *Knudson* and *Owens* directly conflict with reported cases from the Seventh, Eighth and Eleventh Circuits, which specifically reject the reasoning of *Owens*.[5]

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[4] 122 F.3d 1258 (9th Cir. 1997).

[5] *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999); *Blue Cross and Blue Shield of Alabama v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996).

In *Administrative Committee v. Gauf*,[6] the Wal-Mart Associates Health & Welfare Plan (the "Plan") filed suit against Wal-Mart employee Patricia Gauf seeking to compel reimbursement of benefits pursuant to a plan provision requiring reimbursement when employees obtain a third-party tort recovery for damages arising out of the medical condition for which the Plan previously paid benefits. As in the present case, the Plan sued under ERISA Section 502(a)(3) to obtain "other appropriate equitable relief . . . to enforce . . . the terms of the Plan."

Gauf argued that the Plan was, in effect, seeking a legal remedy because the ultimate purpose of the suit was to obtain reimbursement of money, and thus, its action could not lie under Section 503(a)(3). The Seventh Circuit rejected this argument, stating:

> Although the pertinent parts of the complaint employ a variety of terms to express the relief requested, we believe that a fair reading of the document in its totality makes clear that the Committee is seeking an equitable remedy against Ms. Gauf to insure her compliance with the terms of the Plan. For example, the complaint requests "specific performance and enforcement" of the contract and an "order enjoining defendant from continuing to violate the terms of the Plan."[7]

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[6] 188 F.3d 767 (7th Cir. 1999).

[7] *Id.* at 770.

In reaching its conclusion, the *Gauf* Court acknowledged the holding of *Owens* but wholly rejected it, stating that "our Circuit has consistently held that a complaint purporting to state a claim for equitable relief under a reimbursement clause in a benefits contract is an equitable claim for purposes of ERISA Section 502(a)(3)."[8]

The Eleventh Circuit also rejected the *Owens* decision in *Blue Cross and Blue Shield of Alabama v. Sanders*.[9] As in *Owens*, *Gauf*, and the present case, the action in *Sanders* arose out of a plan provision permitting the plan to obtain reimbursement in the event the participant obtained a tort recovery against a third party. As in *Gauf*, the defendants relied upon *Owens*' assertion that a reimbursement claim is an action for legal relief unavailable under 29 U.S.C. § 1132(a)(3).

The Eleventh Circuit squarely rejected this argument, stating that:

> *Owens* appears to be based on an unduly narrow reading of *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993). . . . The Court in *Mertens* did not imply that specific performance is unavailable under 29 U.S.C. § 1132(a)(3)(B).

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[8] 188 F.3d at 771, *citing Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Neurobehavioral Associates, P.A.*, 53 F.3d 172, 173-74 (7th Cir. 1995).

[9] 138 F.3d 1347 (11th Cir. 1998).

> Because specific performance is a traditional form of equitable relief, . . . we believe that specific performance may be equitable relief available under 29 U.S.C. § 1132(a)(3)(B).[10]

The Eighth Circuit, in *Southern Council of Industrial Workers v. Ford*,[11] upheld the right of a plan administrator to proceed under § 1132(a)(3) to enforce a subrogation provision and a written subrogation agreement. The plan administrator sought to compel a plan participant to reimburse the plan for medical expenses previously advanced out of proceeds gained from settlement of a personal injury claim. Holding that the allegation "that Ford admittedly failed to reimburse is a claim that Ford failed to comply with a term of the Plan," the Court found that the Plan's equitable action for unjust enrichment is permitted under ERISA Section 502(a)(3).[12] This holding, along with the decisions noted above from the Seventh and Eleventh Circuits, is directly at odds with the Ninth Circuit's *Owens* decision.

Other courts likewise have permitted actions for restitution or other equitable relief to proceed under ERISA Section 502(a)(3).[13]

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[10] *Id.* at 1352-53, n. 5. *See also In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d 1255, 1268-69 (3d Cir. 1995).

[11] 83 F.3d 966 (8th Cir. 1996).

[12] *Id.* at 969.

[13] *See, e.g., Health Cost Controls v. Isbell*, 139 F.3d 1070 (6th Cir. 1997); *LeBlanc v. Cahill*, 153 F.3d 134

B. The *Knudson* decision conflicts with this Court's decision in *Mertens*.

The *Knudson* panel relied solely upon *FMC Corp. v. Owens,* which conflicts with this Court's decision in *Mertens*.

In *Mertens*, this Court ruled that the 29 U.S.C. § 1132(a)(3) does not allow a suit by plan participants for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty. This Court held that ERISA Section 502(a)(3)'s limitation of remedies to "appropriate equitable relief" means that "money damages" are not recoverable. The Court reasoned that "equitable relief," as used in 29 U.S.C. § 1132(a)(3), means those types of relief that were "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."[14]

This Court, in reaching its decision, however, did not bar equitable remedies which would ultimately result in a monetary recovery. This Court did not, for example, state that specific performance,[15] a traditional form of equitable

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(4th Cir. 1998); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168 (4th Cir. 1998); *Strom v. Goldman, Sachs & Co.*, 202 F.3d 138 (2d Cir. 1999); *Walker v. Rose*, 22 F. Supp. 2d 343 (D.N.J. 1998).

[14] 508 U.S. at 256.

[15] Mandamus–one of the forms of appropriate equitable relief enumerated by the *Mertens* Court–is the

relief,[16] is unavailable under 29 U.S.C. § 1132(a)(3)(B) simply because such a remedy may involve the recovery of money.

In addition, this Court ruled that "restitution" was among "those categories of relief that were typically available in equity. . . . " Other courts of appeals agree. For example, the Seventh Circuit, in *Harris Trust & Sav. Bank*

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equivalent of specific performance. Mandamus is defined as an "extraordinary writ which lies to compel performance of a ministerial act or mandatory duty where there is a clear legal right in plaintiff, a corresponding duty in defendant, and a want of any other appropriate and adequate remedy." Black's Law Dictionary 663 (6th ed. 1991).

[16] *See Owens-Illinois, Inc. v. Lake Shore Land Co., Inc.*, 610 F.2d 1185, 1189 (3d Cir. 1979) ("An action for specific performance without a claim for damages is purely equitable and historically has always been tried to the court."). Other courts and legal scholars have reached the same conclusion: *In re Unisys Corp. Retiree Med. Ben. ERISA Litigation*, 57 F.3d at 1268-69 (specific performance is an equitable remedy); *Fischer Imaging Corp. v. General Electric Co.*, 187 F.3d 1165, 1172 (10th Cir. 1999) (specific performance is an equitable remedy); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 660-61 (6th Cir. 1996) (holding that specific performance is an equitable remedy and "[i]t is well-settled that equitable relief includes monetary damages where required to afford complete relief"); Pomeroy, *A TREATISE ON EQUITY JURISPRUDENCE*, § 1401 (5th ed. 1941); Lawrence, *A TREATISE ON THE SUBSTANTIVE LAW OF EQUITY JURISPRUDENCE*, §§ 255, 256 (1929).

v. Provident Life & Accident Ins. Co.,[17] held that an employer's claim for reimbursement of benefits pursuant to an employee benefit plan provision constituted an action for restitution, an equitable remedy available under §1132(a)(3). The Fourth Circuit, in *LeBlanc v. Cahill*,[18] held that restitution, seeking "to restore the fund to the position it held before," is a category of relief traditionally available in equity, and thus, "falls squarely within the Court's definition of 'appropriate equitable relief' as stated in ERISA Section 502(a)(3)."[19]

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[17] 57 F.3d 608, 615-16 (7th Cir. 1995).

[18] 153 F.3d 134, 153 (4th Cir. 1998).

[19] The Ninth Circuit, while recognizing "other appropriate equitable relief" available under § 1132(a)(3) includes restitution, held that "restitution," as used in § 1132(a)(3), means "ill-gotten gains." In other words, a claim for restitution would not lie unless the claimant was seeking to recover gains obtained through fraud or wrongdoing. 197 F.3d at 1005-7, *citing Owens*, 122 F.3d at 1261. The panel concluded that such circumstances did not exist in the present case because the "payment of Ms. Stone's medical bills by appellants was not obtained through fraud or wrongdoing" since "Cement Masons was required under the terms of the Plan to make those payments." *Id.* at 1007. The Ninth Circuit, in reaching this conclusion however, looked only at one side of the coin. While the plan participant's initial receipt of monies paid from the plan for medical expenses does not involve fraud or wrongdoing, the participant's subsequent failure to abide by *his* reciprocal obligation under the plan to reimburse the plan for benefits paid clearly results in "ill-gotten" gain–as defined by the Ninth Circuit–for the participant in the form of double recovery.

Monetary recoveries are commonplace in restitutionary actions and will not transform the nature of the remedy sought from an equitable into a legal one as the Ninth Circuit in *Owens* implied.[20]

In addressing this issue of "appropriate equitable relief" under ERISA Section 502(a)(3), this Court in *Mertens* explicitly analogizes the phrase "other appropriate equitable relief" to the similar language of Title VII of the Civil Rights Act of 1964, which includes the term "any other equitable relief the court deems appropriate . . . ."[21] Title VII authorizes equitable relief which includes the payment of money; for example, the Supreme Court has

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[20] *Schwartz v. Gregory*, 45 F.3d 1017 (6th Cir. 1995); *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990) (holding that monetary recoveries are considered equitable when "they are restitutionary"); *Health Cost Controls v. Skinner*, 44 F.3d 535, 538 n. 4, 5 and 7 (7th Cir. 1995) ("although [plan administrator] clearly cannot recover compensatory damages under [§ 1132(a)(3)], if it successfully makes out a claim for restitution . . . it may be entitled to monetary relief"); *In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d at 1268-69 (equitable relief under Section 1132(a)(3) includes monetary awards typically available in equity, but not compensatory or consequential damages; granting retirees both specific performance of fiduciary's assurances of post-retirement benefits and restitutionary reimbursement of back benefits).

[21] 508 U.S. at 255.

authorized awards of both back pay and front pay (both monetary remedies) under Title VII, remedies which constitute "equitable relief."[22]

This Court recognized that "[m]oney damages are, of course, the classic form of legal relief."[23] In *Bowen v. Massachusetts*,[24] a case requiring analysis of the statutory exception in 5 U.S.C.A. § 702 denying district court review jurisdiction in actions against federal agencies seeking "money damages," this Court set forth the basic distinctions between an action for damages and an equitable action for specific relief. In particular, this Court held:

> The term money damages . . . normally refers to a sum of money used as compensatory relief. Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies "are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled." D. Dobbs, Handbook on the Law of Remedies 135 (1973).[25]

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[22] *See Albemarle Paper Co. v. Moody*, 422 U.S. 405 (1975); *Roush v. KFC Nat'l Management Co.*, 10 F.3d 392, 398 (6th Cir. 1993) (front pay characterized as equitable).

[23] 508 U.S. at 255.

[24] 487 U.S. 879 (1988).

[25] *Id.* at 895, *quoting Maryland Dept. of Human Resources v. Department of Health and Human Services*, 763 F.2d 1411 (D.C. Cir. 1985).

Employee benefit plans, in attempting to recoup benefits paid on behalf of a plan participant in third-party tort recovery situations, are seeking nothing more than specific remedies. The type of relief typically sought by employee benefit plans in such situations includes specific performance, restitution and/or injunctive relief. In pursuing these remedies, plan fiduciaries seek solely to enforce plan provisions and recoup a specific amount of money that has already been paid out. Plan fiduciaries do not seek money damages in an effort to compensate the plan or substitute for payments made in the first instance. Instead, the employee benefit plans are seeking specific relief in these instances which would grant them the very thing to which they are entitled under their plan terms

The Ninth Circuit, relying upon *Owens*, denies employee benefit plans these specific equitable remedies, concluding that "when the substance of the relief is monetary, . . . such a remedy is not available under section 1132(a)(3)."[26] This holding clearly conflicts with this Court's holding in *Mertens* that mandamus, injunction, or specific performance, which clearly encompass monetary relief, are "appropriate equitable relief" within the meaning of 29 U.S.C. § 1132(a)(3).[27]

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[26] 122 F.3d at 1262.

[27] This Court did not hold that "injunction, mandamus, and restitution" are the *only* forms of appropriate equitable relief. On the contrary, this Court reasoned that "equitable relief," as used in 29 U.S.C. § 1132(a)(3), means those types of relief that were "typically available in equity (*such as* injunction, mandamus, and restitution, but not compensatory damages)." 504 U.S. at 256 (emphasis added). This Court was providing examples of equitable relief, not an exhaustive list as the *Owens*

The Ninth Circuit's decision effectively denies employee benefit plans the right to enforce subrogation and reimbursement provisions in situations where the ultimate recovery would include money. In so doing, the Ninth Circuit has stripped employee benefit plans of a valid and effective cost containment mechanism.

Employee benefit plans do not, as the Ninth Circuit suggested in *FMC v. Owens,* have the option of pursuing in state court claims to recoup medical expenses. In *Descant v. The Administrators of the Tulane Educ. Fund*,[28] for example, an employee benefit plan paid benefits on behalf of a covered person and moved to intervene in the covered person's state court action in order to enforce the plan's recoupment rights. The Louisiana Court of Appeals affirmed the trial court's decision to dismiss the employee benefit plan's petition in intervention because federal courts have exclusive jurisdiction to determine the recoupment rights of ERISA-covered plans:

> The issue of Canal Barge's right of subrogation is a matter to be decided under the federal ERISA statute, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101, *et seq.* Under ERISA, Congress explicitly set forth provisions granting federal district courts exclusive jurisdiction in civil actions brought by fiduciaries intending to enforce the terms of a benefit plan. 29 U.S.C. § 1132(a)(3)(B)(ii). Accordingly, the federal district court has

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panel ruled.

28 706 So. 2d 618 (La. Ct. App. 1998)

> exclusive subject matter jurisdiction to determine whether Canal Barge is entitled to reimbursement pursuant to a subrogation agreement.[29]

Similarly, in *Jefferson Pilot Life Ins. Co. v. Krafka*,[30] a third-party administrator of an ERISA-covered employee benefit plan sought to recoup benefits paid on behalf of a covered person after the covered person recovered from a third party for the same injuries that had been paid by the plan. The California Court of Appeals reversed the judgment granted in favor of the plan and ordered that the complaint against the plan be dismissed because federal courts have exclusive jurisdiction over recoupment actions brought by ERISA plan fiduciaries:

> . . . [T]he federal courts have exclusive subject matter jurisdiction of civil lawsuits under ERISA, except for actions under Title 29 of the United States Code, § 1132(a)(1)(B) and (a)(7); the state courts have concurrent jurisdiction in matters arising under those sub-divisions. Section 1132(a)(1)(B) and (a)(7) authorize actions, respectively: "by a participant or beneficiary . . . to recover benefits due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan" and "by a state to enforce compliance with a

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29 *Id.* at 627.

30 50 Cal. App. 4th 190 (1996).

> qualified medical child support order . . . ." Plaintiff is not a plan participant or beneficiary, nor is it a state. Therefore, plaintiff is not a proper party to bring an action in the state court under ERISA, § 1132(a)(1)(B) or (a)(7). In other words, any action plaintiff may be able to bring under ERISA is not a lawsuit as to which this court can exercise concurrent subject matter jurisdiction. In the absence of subject matter jurisdiction, plaintiff's complaint must be dismissed.[31]

Because of the Ninth Circuit's decision in this case and ERISA's bar against fiduciaries pursuing actions in state court to enforce plan terms, employee benefit plans have no recourse to recoup medical expenses in third-party liability situations except to exclude coverage for such expenses. This Court should grant the Petition and consider this case on the merits.

II. This Court should grant the petition to resolve a conflict among the federal courts of appeals and a decision of this Court over whether a court may award attorney's fees under a federal statute after finding that the court has no subject matter jurisdiction under that statute.

This Court, the Ninth Circuit, and every other Circuit that have addressed the issue has held that, if a court lacks subject matter jurisdiction under a federal statute, then the court has no authority to award attorney's fees under

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[31] *Id.* at 194-95.

that statute.[32] The *Knudson* decision conflicts with these decisions in holding that "[e]ven in the absence of subject matter jurisdiction, a district court has the power to award attorneys fees."[33] While the Court purports to rely upon prior authority from the Ninth Circuit for this proposition, the authority relied upon, *Moore v. Permanente Medical Group, Inc.*,[34] does not support the holding announced by the *Knudson* panel under the facts presented there.

In *Moore,* the defendant removed a case from state court to federal district court, and the district court granted the plaintiff's motion to remand to state court. After remand, the plaintiff moved for an award of attorney's fees for improper removal under 28 U.S.C. § 1447(c), which the court granted. The defendant appealed to this Court, contending that "because the fee award was not included in the district court's remand order, the district court did not have jurisdiction to award fees."[35]

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[32] *National Private Truck Council v. Oklahoma Tax Commission*, 515 U.S. 582, 592 (1995) ("It follows that when no relief can be awarded pursuant to § 1983, no attorney's fees can be awarded under § 1988."); *Branson v. Nott*, 62 F.3d 287 (9th Cir. 1995); *W.G. v. Senatore*, 18 F.3d 60 (2d Cir. 1994); *Keene Corp. v. Cass*, 908 F.2d 293, 298 (8th Cir. 1990).

[33] Addendum A, Ninth Circuit Opinion, p. A-4.

[34] 981 F.2d 443 (9th Cir. 1992).

[35] *Id.* at 445.

This Court rejected the defendant's argument based upon a Supreme Court decision, *Cooter & Gell v. Hartmarx,*[36] which holds that a federal court retains jurisdiction after a voluntary dismissal to rule on collateral matters that are "supplemental to the original proceeding, such as a motion for sanctions pursuant to Rule 11 of the Federal Rules of Civil Procedure. In *Moore,* this Court held, consistent with *Cooter & Gell*, that a court retains jurisdiction after remand of a removed action to award attorney's fees for improper removal pursuant to 28 U.S.C. § 1447(c). This holding does not support the rule announced in the *Knudson* decision.

One decision from the Ninth Circuit, which was available to the *Knudson* panel, noted that the principle that allows a court to award Rule 11 sanctions, despite the fact that the court no longer has subject matter jurisdiction over the action, is distinguishable from the situation presented here. In *Branson,* this Court held that the absence of subject matter jurisdiction under a statute bars an award of attorney's fees under that statute. The *Branson* Panel pointed out the fallacy of the *Knudson* Panel decision by distinguishing a prior panel opinion from the Ninth Circuit, which "affirm[ed] dismissal of § 1983 action for lack of subject matter jurisdiction while also affirming district court's award of attorney's fees, where fees had been awarded under 42 U.S.C. § 1988 and, alternatively, under Fed. R. Civ. P. 11."[37] In *Branson*, as in the present case, there was no motion or ruling regarding Rule 11 sanctions. The district court premised its attorney's fee award solely upon ERISA.

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[36] 496 U.S. 384 (1990).

[37] *Branson,* 62 F.3d at 293.

A case that was decided eight days before the Ninth Circuit denied Petitioners' Suggestion for Rehearing *En Banc* provides additional support that *Knudson* was wrongly decided and conflicts with other decisions of the Ninth Circuit. In *In re Knight,*[38] the Ninth Circuit held that a district court, without subject matter jurisdiction under ERISA, could not award attorney's fees under ERISA.

CONCLUSION

The split among the circuits as to whether an employee benefit plan fiduciary may recoup benefit payments in third-party liability situations under ERISA Section 503(a)(3) threatens an important aspect of cost containment for employee benefit plans. The Ninth Circuit incorrectly interpreted this Court's decision in *Mertens* as barring claims under Section 503(a)(3) whenever the remedy involves a monetary recovery.

This Court should grant the Petition and resolve the split among the circuits, providing guidance on how to properly contain cost through the use of subrogation and reimbursement provisions, and reaffirm that a federal court, without subject matter jurisdiction under a federal statute, may not award attorney's fees under that statute.

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[38] 207 F.3d 1115 (9th Cir. 2000).

Respectfully submitted,

Thomas H. Lawrence
Counsel of Record for Petitioners

Lewis Fisher Henderson
& Claxton, LLP
5050 Poplar Avenue, Suite 1717
Memphis, Tennessee 38157
(901) 767-6160

Dated: May 8, 2000.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et. al., Plaintiffs-Appellants,

v.

Janette KNUDSON and Eric Knudson, Defendants-Appellees.

No. 98-56472.
D.C. No. CV 97-03745-JMI.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Sept. 13, 1999.

Decided Feb. 7, 2000.

Appeal from the United States District Court for the Central District of California, James M. Ideman, District Judge, Presiding.

Before B. FLETCHER, PREGERSON, Circuit Judges, and WEINER, [FN2] Senior District Judge.

FN2. Charles R. Weiner, Senior United States Judge for the Eastern District of Pennsylvania, sitting by designation.

MEMORANDUM [FN1]

FN1. This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as may be provided by Ninth Cir. Rule 36-3.

Great-West Life & Annuity Insurance Company ("Great-West"), Earth Systems, Inc. and the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. appeal the district court's judgment adverse to them in their action seeking to enforce a contractual reimbursement provision pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA") § 502(a)(3), 29 U.S.C. § 1132(a)(3) against Janette and Eric Knudson ("Knudson"). We affirm the district court's judgment but do so on grounds different from those relied on by the district court.

Defendants Eric and Janette Knudson were involved in an auto accident, which left Janette a paraplegic. At the time of the accident, she was covered by the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. ("the Plan"). Following the accident, the Plan paid benefits totaling $411,157.11 to Knudson and her medical providers. The Plan includes a reimbursement provision giving the Plan a right to recover third party payments to Knudson up to the amount of the benefits paid by the Plan. The Plan also had a "Stop-Loss" insurance agreement with Great-West which gave Great-West the right to recover first any amounts reimbursing the Plan. Knudson was required also to execute an agreement to reimburse as a condition of receiving payments under the Plan.

Knudson filed suit in state court against Hyundai Motors and others allegedly responsible for the accident. The parties settled for $650,000. The state court ultimately approved the settlement and resolved the status of various competing lienholders to the settlement. [FN3] The settlement attributed five percent of the award to prior medical expenses. Knudson's attorney sent a check to Great- West for $13,828.70, representing 5% of the award. Rather than accept this amount, Great-West, Earth Systems, and the Earth

Systems Plan filed suit in federal district court claiming entitlement to $411,157.11 of the settlement.

> FN3. Prior to the state court's final approval of the settlement, Great- West removed the action to federal district court. The district court remanded to state court, noting that Great-West was never a party to the state court action. None of the issues surrounding the removal are before the panel in this appeal and neither party has appealed the state court ruling.

Ruling on cross-motions for summary judgment, [FN4] the district court held that the plain terms of the Plan limited the Appellants' reimbursement to the amount received by Plan beneficiaries from third parties for medical treatment. Because the state court oversaw the settlement and awarded Knudson only $13,828 for medical treatment, the district court simply acknowledged that the Appellants' right to reimbursement was limited to that amount. The court granted summary judgment in favor of Knudson. The district court also granted Knudson's request for attorneys fees in the amount of $80,497.50.

> FN4. Motions for preliminary injunction, disqualification of counsel, the striking of the jury demand, for judicial notice, and to file an amended complaint were also before the district court judge. In this appeal, Great- West has not challenged the district court's rulings with respect to the motions.

ERISA provides fiduciaries an exclusive forum in federal courts to enforce provisions of an ERISA plan. See 29 U.S.C. § 1132(e)(1). The Appellants seek to bring an action under 29 U.S.C. § 1132(a)(3) which requires that they be seeking equitable, rather than legal relief. We held, in FMC Medical Plan v. Owens, 122 F.3d 1258, 1262 (9th Cir.1997),

that reimbursement of payments made to a beneficiary of an insurance plan by a third party, which Appellants seek here, is not equitable relief within the meaning of § 1132(a)(3). [FN5]

Appellants contend that Owens was wrongly decided and seek en banc review. However, we have recently reaffirmed the holding in Owens and, therefore, decline to seek en banc review. See Reynolds Metals Co. v. Robert Ellis, ____ F.3d ____ (9th Cir.2000).

FN5. Owens rests its dismissal on the lack of subject matter jurisdiction. But see Cement Masons Health and Welfare Trust Fund for Northern California v. Stone, 197 F.3d 1003, 1008 (9th Cir.1999) (reaffirming the substantive holding in Owens but dismissing on the merits rather than on subject matter jurisdiction). For our purposes, in evaluating the substantive holding of Owens requiring the dismissal of reimbursement claims for third party settlements under ERISA, the dismissal could be based either on lack of subject matter jurisdiction or on the merits.

We also affirm the district court's award to Knudson of attorneys fees in the amount of $80,497.50. [FN6] Even in the absence of subject matter jurisdiction, a district court has the power to award attorneys fees. See Moore v. Permanente Medical Group, Inc., 981 F.2d 443 (9th Cir.1992).

FN6. Appellants challenge the right to attorneys fees, not the amount.

Accordingly we affirm the district court's judgment. AFFIRMED.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, *et al.*,	)	CV 97-3745 JMI (Jgx)
Plaintiffs,	)	ORDER GRANTING PLAINTIFFS' MOTION TO REMAND
v.	)	ORDER REMANDING ACTION TO LOS ANGELES SUPERIOR COURT
JANETTE KNUDSON, *et al.*,	)	
Defendants.	)	

IT IS HEREBY ORDERED:

Plaintiffs Janette Knudson, et al.'s Motion to Remand came before this Court for review on June 2, 1997. After careful consideration and review, the Court hereby GRANTS Plaintiffs' motion.

BACKGROUND

Plaintiff, Janette Knudson, was involved in an automobile accident while driving a car manufactured by Hyundai Motors of America, Inc. Plaintiffs filed suit against Hyundai Motors of America, et al., in the Superior Court of the State of California for the County of Los Angeles. See Janette Knudson, et al. v. Hyundai Motors of America, Inc., et al.; Case No. LC022329. The dispute between Plaintiffs and Hyundai was to be settled by way of the establishment of a trust fund for Plaintiff.

Great-West Life and Annuity Insurance Company ("Great-West") is the assignee of the health insurance company that initially paid Plaintiff's medical expenses following the accident. Great-West, claiming to be a defendant, removed Plaintiffs' case against Hyundai, et al., to federal court before the trust fund could be approved by the state court. Now, Plaintiffs request that the case be remanded back to state court.

DISCUSSION

I. Section 1441 Procedure

Except as otherwise expressly provided by Act of Congress, any civil action brought in a state court of which the district courts of the United States have original jurisdiction, may be removed by the defendant to the district court of the United States for the district and division embracing the place where such action is pending. 28 U.S.C. § 1441. *Accordingly, only a defendant has the power to remove a case to federal court.*

II. Great-West Does Not Qualify as a Defendant Under 28 U.S.C. § 1441.

Great-West is a party-in-interest in the instant case to the extent that it hopes to receive compensation from the trust fund for the medical payments it made following Plaintiff's accident. Great-West, however, was never included as a party in Knudson v. Hyundai, and it is in no position to qualify itself as a defendant. Not Plaintiffs, nor any other party in this matter, have made any claims against Great-West. It is Great-West that has a complaint against Plaintiffs. In fact, Great-West has already filed a separate complaint in this court seeking compensation from Plaintiffs. See Great-West Life &

Annuity Ins. Co. v. Janette Knudson, et al.; CV 97-3745 JMI (JGx).

Plaintiffs have filed a Motion for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors. In the motion, Plaintiffs ask the state court to approve the settlement reached with Hyundai. The proposed settlement includes a provision providing compensation to parties for past medical expenses. Great-West, however, does not qualify as an adversarial party in the motion. Great-West is only a party-in-interest to the extent that it is to receive compensation from the trust fund as part of the provision providing compensation to parties for past medical expenses. The state court is to decide whether or not the settlement is fair to the parties involved. If the state court finds that the proposed settlement is not fair to Great-West, it will not approve the settlement. Great-West is not in a position to itself oppose Plaintiffs' motion for approval.

III. Great-West Does Not Qualify as a Defendant Under Fravel v. Stankus

Great-West claims that it qualifies as a defendant under the holding in Fravel v. Stankus, 936 F. Supp 474 (N.D. Ill. 1996), a case from the Northern District of Illinois. In Fravel, the injured plaintiff filed a Motion to Adjudicate Lien against a subrogee of a health plan that had made medical payments on behalf of the plaintiff. Id. at 476. The motion was made in connection with a settlement the plaintiff reached with the defendant in the case. The court held that the health plan subrogee qualified as a defendant in the plaintiff's state case because "the action [was] clearly adversarial in nature." Id. at 480 (citation omitted).

The holding in Fravel, however, does not apply to the instant case. Plaintiffs never filed a Motion to Adjudicate Lien against Great-West. In fact, Plaintiffs dispute Great-West's contention that a lien ever existed. See Plaintiffs' Motion, p. 4.

IV. Great-West has Filed a Separate Complaint Against Plaintiff

Plaintiffs' Motion to Remand is strengthened by the fact that Great-West has already filed a separate ERISA related complaint against Plaintiffs in federal court seeking compensation for the payments it made relating to Plaintiff's accident. See Great-West Life & Annuity Ins. Co. v. Janette Knudson, et al.; CV 97-3745 JMI (JGx). It would be improper to allow Great-West to file a separate complaint against Plaintiffs for compensation and at the same time qualify itself as an adverse party in Plaintiffs' case against Hyundai. Such an outcome would not be in the interests of justice, as Great-West would be seeking compensation for the same expense from two separate sources. By filing a separate federal complaint, Great-West has mooted its argument for removing Plaintiffs' case against Hyundai.

IT IS SO ORDERED

DATED: June 27, 1997

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JAMES M. IDEMAN
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, *et al.*,	)	
Plaintiffs,	)	CV 97-3745 JMI (Jgx)
v.	)	
JANETTE KNUDSON, *et al.*,	)	ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY
Defendants.	)	JUDGMENT

IT IS HEREBY ORDERED:

The following motions came before the Court on March 23, 1998:

Plaintiff's Motion For Summary Judgment;
Plaintiff's Motion For Preliminary Injunction;
Plaintiff's Motion To Disqualify Defendant's Counsel;
Plaintiff's Motion To Strike Defendant's Jury Demand;
Plaintiff's Motion To File Second Amended Complaint;

Defendant's Request For Judicial Notice;
Defendant's Motion For Summary Judgment.

Pursuant to Federal Rule of Civil Procedure 78 and Central District of California Local Civil Rule 7.11, the Court dispensed with oral argument on the motions, and Court took

the motions under submission. After careful and exhaustive review, considering all pertinent papers on file, the arguments, and materials presented by the parties, the Court hereby takes judicial notice of requested documents, GRANTS Summary Judgment in favor of Defendants, and DENIES the remaining motions.

BACKGROUND

This action arises under the Employee Retirement Income Security Act of 1974 ("E.R.I.S.A."), codified at 29 U.S.C. § 1001 et. seq. Plaintiff Great-West Life & Annuity Insurance Company ("Great-West") is the assignee for collection of the health and welfare plan for employees of Earth Systems, Inc. ("Earth Systems"). Defendants are Janette and Eric Knudson, husband and wife. Mr. Knudson was an employee of Earth Systems when he and his wife were involved in an automobile accident which left Mrs. Knudson a quadriplegic for life.

The Health and Welfare Plan for Employees of Earth Systems ("The Plan") paid out $411,157.11 in medical benefits for Janette Knudson's medical care. The Plan had a "Stop-Loss" insurance agreement with Great-West, whereby the Plan would pay any benefits up to $75,000 and Great-West would pay any excess amount. Additionally, the stop-loss allowed Great-West the right to recover first from amounts paid to the Plan by third parties. The stop-loss limits the Plan's risk of dissipating all of its assets for a single member.

Defendants in 1993 sued Hyundai Motors of America, and others, in L.A. Superior Court. Though Plaintiff Great-West was the assignee with rights of subrogation on an E.R.I.S.A. funded policy, it did not at any time seek to intervene in that action. Instead, when the Knudsons and

Hyundai agreed on a $650,000.00 settlement and notified Great-West that the Superior Court would rule on the fairness of the settlement and status of liens on the settlement, Great-West removed that case to federal court (Knudson, et al. v. Hyundai Motors of America, Inc., et al.), CV 97-2801 JMI (ANx)). This Court remanded that case because Great-West, a non-party in that action, had no right to remove the case.

At the same time, Plaintiffs filed the instant action (probably to hedge their bets against remand in the other case). Plaintiff Great-West alleges that it is entitled to $411,157.11 of any settlement proceeds because it paid out that amount in plan benefits to pay for medical expenses. Because the E.R.I.S.A. plan provided for first-lien reimbursement of medical expenses recovered from third parties, Plaintiff Great-West argues that it is entitled to injunctive relief.

Following remand, the Superior Court considered the fairness of the settlement and the status of creditors' liens on settlement funds. The settlement agreement, which provided $650,000.00 to the Knudsons, allocates damages as follows:

Loss of Earnings	5%
Past Medical Expense	5%
Future Medical Expense	45%
Loss of Enjoyment of Life; Distress; Long-Term Disability	40%
Other	5%

Because past medical expenses reflect only five per cent of the settlement amount, Plaintiff Great-West was not entitled to full subrogation under the settlement agreement. By Orders on July 23, 1997 and August 1, 1997 the Superior Court approved the settlement and directed payment of funds

to the Janette Knudson Special Needs Trust and to disputed creditors. Under the authorized settlement, Knudson's attorney sent a check to Great-West for $13,828,70, five percent of the settlement. Great-West did not cash the check, but requested that Knudson's attorney segregate all of the settlement funds pending the outcome of the present case in Federal Court. Knudson's attorney refused because monies had gone directly from Hyundai to the Knudson Special Needs Trust. Plaintiff's Motion for injunctive relief seeks segregation of the disbursed funds and attorney's fees.

ANALYSIS

The Court decides the motions in the following order because the ruling on certain motions obviate the need to consider the remaining motions:

I. Defendant's Request for Judicial Notice;
II. Cross Motions For Summary Judgment;
III. Plaintiff's Motion To Strike Defendant's Jury Demand;
IV. Plaintiff's Motion For Preliminary Injunction;
V. Plaintiff's Motion To Disqualify Defendant's Counsel;
VI. Plaintiff's Motion For Leave To File a Second Amended Complaint;

I. Defendant's Request for Judicial Notice

Defendant Janette Knudson requests that the Court take judicial notice of certain pleadings and orders in Knudson v. Hyundai, Los Angeles County Superior Court Case No. LC 022329 and District Court Case No. 97-2801 JMI (ANx) (while removed and prior to remand). Federal Rule of

Evidence 201 allows a court to take judicial notice of pleadings, orders, and decisions by the same or other courts. See Papai v. Harbor Tug and Barge Co., 67 F.3d 203 (9th Cir. 1995).

This Court takes judicial notice of the documents associated with motions and orders approving settlement in Superior Court and the file compiled while the case was removed to this Court.

The Court does not expressly rule on the parties' evidentiary objections. However, the Court thoroughly considered each, where pertinent, and disregarded inadmissible evidence. The Court did not base its conclusion on evidence that the Court would deem inadmissible at trial. Hal Roach Studios v. Richard Feiner & Co., 896 F.2d 1542, 1555 (9th Cir. 1990).

II. Cross Motions for Summary Judgment

Preemption and Exclusive Jurisdiction Under ERISA.

Defendant Janette Knudson was a "Covered Person" under the Plan. The parties agree that ERISA preempts the substantive state law governing this action. Plaintiffs, however, maintain that ERISA also gives the federal courts exclusive jurisdiction over this dispute, and that the Superior Court lacked subject matter jurisdiction to determine lien rights as defined by the Plan. Further, Plaintiffs argue that they could not pursue their claims for reimbursement in the state court because federal courts have exclusive jurisdiction over actions where a plan seeks equitable relief.

The ERISA statute defines the scope of jurisdiction over ERISA disputes: "State courts of competent jurisdiction

and district court of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section." 29 U.S.C. § 1132(e)(1). Paragraph (1)(B) states that a beneficiary may bring a civil action "to enforce rights under the terms of the plan." 29 U.S.C. 1143(a)(1)(B). The state court action to determine the status of liens on Janette Knudson's recovery is an action to enforce her rights under the terms of the Earth Systems Plan.

Plaintiffs note that "State courts have concurrent jurisdiction over ERISA claims only if the claim is one by a participant against a plan where the participant is seeking to recover benefits under 29 U.S.C. § 1132(a)(1)(B)." Plaitniff's Points and Authorities, at p. 3 n. 2 (emphasis added). Plaintiffs misstate the law. The concurrent jurisdiction includes more than "only" what Plaintiffs allege. See Schwarzer, et al., Cal. Prac. Guide: Fed. Civ. Pro. Before Trial § 2:38 (TRG 1998) (citing Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 (1983)). The statute clearly states that concurrent jurisdiction includes actions to recover benefits, to enforce rights under the terms of the Plan, and to clarify future benefits.

Plaintiffs correctly state that the federal courts have exclusive jurisdiction over an ERISA case seeking injunctive relief. 29 U.S.C. 11342(e)(1). Plaintiffs seek injunctive relief in this Court but never intervened in the state court action. The fact that Plaintiffs might have sought injunctive relief, does not deprive the state court of jurisdiction to enforce legal rights under the plan. Likewise, the fact that Plaintiffs may have mistakenly thought the state court lacked jurisdiction, does not strip that court of jurisdiction.

Therefore, the Court finds that the Superior Court had subject matter jurisdiction to determine the status of liens on

Knudson's recovery.

Standard for Summary Judgment

A motion for summary judgment provides a procedure for terminating without trial actions in which "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). It is the moving party's burden to show the district court that there is an absence of essential evidence to support the opposing party's case. Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986). The court must view the evidence presented in the motion in the light most favorable to the opposing party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). However, the judge's function is not to weigh the evidence and determine the truth of the matter, but to determine whether there is a genuine issue for trial. Id. at 249-255.

The Plan's Reimbursement Rights

Plaintiff claims that the terms of the Plan provide for full, first lien, reimbursement to the extent of benefits paid from amounts recovered by the covered person from third parties. Based on this reading of the Plan, Plaintiffs contend that Knudson should have to pay the first $411,157.11 of any recovery to Plaintiffs. Plaintiffs state that a covered person's allocation of settlement funds is irrelevant to the determination of reimbursement rights where a benefit plan defines the scope of those rights.

Defendant Knudson argues that the Plan expressly limited Plaintiffs recovery to the amount paid out for medical expenses. Because the settlement allocated 5% of the total recovery for past medical expenses, Defendant refuses to pay more than the five percent less attorneys fees.

The Earth System Plan states that the Plan will pay benefits to covered party, even when a third party may be liable, but reserves a right of recovery as follows:

> "We will, at our sole option, have the right to recover from the Covered Person any payment for benefits paid for treatment of such Loss under this Booklet which the Covered Person is entitled to receive from the third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person receives from . . . [third parties].
> The lien will not exceed:
> -the amount of benefits paid under this Booklet for the treatment of Loss; or
> -the amount received by the Covered Person for such medical treatment from the third party."

Exhibit B to Plaintiff's Motion for Summary Judgment.

The Right of Recovery Agreement Signed by Eric Knudson

In addition to the terms of the Plan, the Plan required that Eric Knudson sign a "Right of Recovery Agreement" prior to the Plan paying any of Janette Knudson's medical bills. See Exhibit 16 to combined motions. Unlike the terms of the Plan, the Agreement states that the Plan will have the right to reimbursement from "any" third party recovery and an automatic first lien.

The Agreement contains a number of flaws that render it useless for the purposes of the motions presently before the Court. First, the Agreement clearly misstates the rights as

established by the Plan. Second, the Agreement purports to be made in consideration of the Plan paying benefits under the Plan. The Plan cannot use a preexisting obligation as consideration for a later contract. Finally, the term of the Plan, itself, forbid alteration of the obligations without formally amending the official Plan documents. A plan administrator cannot amend a plan to divert resources from a beneficiary to the employer. Jacobson v. Hughes Aircraft Co., 105 F.3d 1288, 1292 (9th Cir. 1997). Because the Right of Recovery Agreement misstates the terms and obligations of the Plan, it is appropriate that the Court disregard the Right of Recovery Agreement in determining Plaintiffs rights under the Plan.

Interpretation of the Plan

The terms of the Plan authorize the Plan Administrator to interpret the language of the Plan. Courts will not upset the administrator's interpretation of an ERISA plan unless the interpretation is arbitrary and capricious. Canseco v. Construction Laborers Pension Trust for Southern California, 93 F.3d 600, 606 (9th Cir. 1996). In this case, Jerol Brown, an employee of Earth Systems, was vented with the authority to interpret the Plan. Mr. Brown interpreted the Plan to allow the Plan through Great-West, as the stop loss carrier, to be reimbursed 100% of any third party recovery. Based on Mr. Brown's interpretation, Great-West, the Plan, and Earth Systems seek to recover all of the $411,157.11 for Defendant's settlement with Hyundai. An interpretation of a plan which imposes additional terms which clash with the terms of a plan is considered arbitrary and capricious. Id. Mr. Brown's interpretation of the Plan clashes with the terms of the Plan. A reviewing court should not defer to an interpretation of the plan that is flawed. Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1323 (9th Cir. 1995).

The terms of the Plan are abundantly clear in providing for a first lien and limits of reimbursement. Under the facts of the present case, the Plan is limited to recovering no more than the amount of benefits paid out or the amount received from a third party for medical treatment. Therefore, Plaintiffs may recover the lesser of, the $411,157.11 or the portion of the $650,000 that is attributable to medical expenses.

Since the Superior Court had proper jurisdiction and concluded that five percent of the settlement is attributed to Plaintiffs' lien, that matter is resolved.

Therefore, Defendant are entitled to summary judgment finding that five percent of the settlement is allocated to medical expenses.

III. Plaintiff's Motion to Strike Defendant's Jury Demand

The present claim is brought under the ERISA statute, which has been construed not allow for a jury trial. Spinelli v. Gaughan, 12 F.3d 853, 857 (9th Cir. 1993) at § 16.45. The right to a jury trial in federal court is a matter of federal law. In this case, where the statutory remedy is more analogous equity, the parties are not entitled to a jury trial. See Id.

The Court finds it unnecessary to strike the jury demand in light of the ruling on summary judgment.

IV. Plaintiffs' Motion for Preliminary Injunction

Plaintiffs seek a preliminary injunction to prevent Knudson, her attorney, and the trustee of the Janette Knudson Special Needs Trust from dissipating settlement funds before Plaintiffs are able to obtain a final ruling in the present suit.

The Court denies this motion in light of the ruling on summary judgment.

V. Plaintiff's Motion to Disqualify Defendant's Counsel

Plaintiffs move to disqualify Jeffery S. Pop, and the law firm of Jeffrey S. Pop & Associates (collectively "Pop") from representing Defendant Knudson in this action because a conflict of interest exists. Under the terms of Knudson's insurance policy, Plaintiff's have a lien on the proceeds of her personal injury settlement. Pop acknowledged the lien in a letter to Plaintiffs in September 1995. Plaintiffs reason that by acknowledging the lien and then distributing the settlement proceeds as ordered by the Superior Court, Pop created some sort of conflict of interest.

Plaintiffs do not adequately explain their allegations of multiple representation and conflict of interest. The California Bar Rules require written disclosure to a client when the bar member's relationships or interests will affect the representation of the client. See California Bar Rules, Professional Conduct Rule 3.31(B). There is no evidence that the mere existence of a lien creates such a relationship. Even if such a situation was created by the facts of this case, the Rules would merely obligate Pop to provide written disclosure.

Plaintiffs further allege that Pop's contingent fee agreement creates a conflicting financial interest. The fee agreement is itself a written disclosure, resolving any potential conflict.

The motion appears meritless.

VI. Plaintiff's Motion For Leave to File Second Amended Complaint

The Court denies this motion in light of the ruling on summary judgment.

CONCLUSION

Summary Judgment is hereby GRANTED in favor of Defendants.

The Court adopts the stipulation of facts between the parties filed on February 13, 1998.

The Court finds law and facts as stated above. Additionally, the Court adopts Defendants' Statement of Law and Facts lodged on February 2, 1998. The Court strikes the following findings because they are either unsupported or unnecessary in the resolution of the present motions:

Uncontroverted facts 2, 15, and 28;

Conclusions of law 4, 5, 7, 10, 13, 14, and 15.

IT IS SO ORDERED.

DATED: May 14, 1998.

JAMES M. IDEMAN
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, *et al.*,	)	
Plaintiffs,	)	CV 97-3745 JMI (Jgx)
v.	)	ORDER GRANTING DEFENDANTS' MOTION FOR ATTORNEY FEES
JANETTE KNUDSON, *et al.*,	)	
Defendants.	)	ORDER DENYING RECONSIDERATION

IT IS HEREBY ORDERED:

The following motions came before the Court on July 6, 1998:

Plaintiff's Motion For Reconsideration; and
Defendant's Motion For Attorney Fees.

Pursuant to Federal Rule of Civil Procedure 78 and Central District of California Local Civil Rule 7.11, the Court dispensed with oral argument on the motions, and the Court took the motions under submission. After careful review, considering all pertinent papers on file, the arguments, and materials presented by the parties, the Court hereby DENIES reconsideration and GRANTS $80,497.50 in attorney fees.

BACKGROUND

Defendant, Janette Knudson was rendered quadriplegic in an automobile accident. Plaintiff, Knudson's insurance carrier, paid out over $411,000 in medical benefits and had a lien against any recovery of medical expenses obtained by Defendant from a responsible third party. Defendant obtained a settlement of $650,000 from an automobile manufacturer in Superior Court. The Superior Court allocated only 5% of the settlement to past medical expenses.

This Court entered summary judgment for Defendant, enforcing the Superior Court's allocation against the Plaintiff. Plaintiff seeks reconsideration of that ruling and Defendant seeks attorney's fees as authorized under ERISA.

DISCUSSION

I. AWARD OF ATTORNEY FEES

This Court has discretion to award attorney's fees to either party in any action brought under ERISA. ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1). The Court may, in its discretion, award attorney fees to a prevailing ERISA plan participant. Sokol v. Bernstein, 812 F.2d 559, 560 (9th Cir. 1987). The parties agree that the Court should broadly look to five primary factors to determine whether award of attorney's fees is appropriate. Hummell v. S.E. Rykoff & Co., 634 F.2d 446 (9th Cir. 1980). The factors set forth in Hummell are: (1) the degree of culpability or bad faith by the opposing party; (2) the ability of the opposing party to pay the award; (3) whether the award would deter future similar action by the opposing party; (4) whether plaintiff sought to benefit all ERISA participants or resolve a significant legal question; and (5) the relative merits of the parties' positions. Here, all

factors, except the fourth factor, counsel in favor of awarding attorney fees to Defendant. The fourth factor is not directly relevant because Defendant did not bring this action. Therefore, the Hummel method of analyzing ERISA fees supports Defendant's requests for $80,497.50 in fees.

II. DOCUMENTATION AND ADJUSTMENT OF FEES

Kerr v. Screen Extras Guild, Inc. stands for the principle that trial courts have discretion in awarding fees, and that the courts shall consider certain factors in exercising that discretion. 526 F.2d at 70. The guidelines are just that - guidelines. The prevailing party is not required to ritualistically mention every Kerr factor, especially when many of them do not apply to the case. The relevant factors in this case are: time, labor, and skill required; novelty and difficulty of issues; preclusion of other employment due to time limitations imposed by circumstances; type of fee and the customary fee; the undesirability of the case; the amount involved and the results obtained in the case; and fee awards in similar cases. See id. The amount of fees appears reasonable in light of the relevant factors and circumstances.

Defendant provided detailed information regarding the experience levels of counsel, their billing rates, specific information pertinent to this case, and extensive billing records. One of Defendant's attorneys, Jeffrey S. Pop charged $250 per hour, and the other attorney, Richard MacNaughton, charged $300 per hour. Pop billed 189.15 hours and MacNaughton billed 110.7 hours for a grand total of $80,497.50.

Plaintiff complains that the attorneys charge a premium for rather simple work, and that both attorneys bill for completing what appears in the records to be the same task.

Plaintiff fails explain which particular charges were duplicative and does not show that the rates charged are unreasonable in light of the complexity of issues presented.

A review of the records supplied as exhibits to declarations shows that Defendant's attorneys billed some large blocks of time in preparing and reviewing briefs for motions and cross-motions. Ordinarily, this might give the Court pause. However, the motions in this case were factually, procedurally, and legally complex. In fact, the final dispositive motion combined seven separate and distinct motions. The moving papers, exhibits, and court-generated research filed two banker's boxes. Due to the complex nature of the suit and the lack of particular objections to individual charges, the award of fees as requested is appropriate.

III. CONTINGENCY MULTIPLIER

In exceptional cases, the court may take the reasonable attorney fees and increase them by a multiple to account for various factors, including the risky contingency nature of the fee agreement. The Ninth Circuit has held that district courts do not have discretion to apply a multiplier to increase statutory attorney fees for contingency risk in ERISA cases. Cann v. Carpenters' Pension Trust Fund, 989 F.2d 313, 317-18 (9th Cir. 1993).

Consequently, Defendant is not entitled to a multiple increase in fees.

IV. STANDARD FOR RECONSIDERATION

A Motion for Reconsideration may be granted only on the grounds of: (1) a material difference in fact or law from that presented to the court that in the exercise of reasonable

diligence could not have been known to the party moving for reconsideration at the time of decision; (2) the emergence of new material facts or a change of law occurring after the time of decision; or (3) a manifest showing of a failure to consider material facts presented to the Court previously. C.D. Cal. R. 7.16.

Parties may request a court to reconsider an order granting a motion for summary judgment by a motion pursuant to Rule 59(e) or Rule 60(b) of the Federal Rules of Civil Procedure. Fuller v. M.G. Jewelry, 950 F.2d 1437, 1442 (9th Cir. 1991). Rule 59(e) provides that a motion to amend or alter is proper where the motion is necessary to correct manifest errors of law or fact upon which the judgment is based or to prevent manifest injustice. 11 Charles A. Wright & Arthur R. Miller, Federal Practice and Procedure, § 2810.1 at 125-26.

Plaintiff's present motion and arguments focus primarily on issues that were fully briefed, considered, and decided in the motion. The briefs do not rely on law or facts that were not presented previously and Plaintiff has made no showing that manifest injustice impends.

Having fully considered the briefs, the Court find insufficient basis, under the above standards, to reconsider this Court's grant of summary judgment.

CONCLUSION

The Court hereby DENIES reconsideration of the Order granting summary judgment. The Court hereby GRANTS Defendant's motion for $80,497.50 in attorney fees pursuant to 29 U.S.C. § 1132(g)(1).

IT IS SO ORDERED.

DATED: July 9, 1998

James M. Ideman
United States District Judge

Supreme Court, U.S.
FILED
JUN 9 - 2000
CLERK

(4)

No. 99-1786

IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT JANETTE KNUDSON

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

Attorneys for Respondent Janette Knudson

160268

Counsel Press LLC
(800) 274-3321 • (800) 359-6859

32 pp

QUESTIONS PRESENTED

1. Whether an ERISA plan fiduciary may intervene or file a lien in state court to enforce its recoupment provision in order to avoid multiplicity of actions.

2. Whether an ERISA plan fiduciary seeking collection from its beneficiary under a recoupment (subrogation) provision in the plan may ignore timely notice of state court proceedings to determine the amount of money available for recoupment as well as for other lien-holders, and instead later bring a separate action against the beneficiary in federal court to relitigate the amount.

3. Whether a court may award attorney's fees under either ERISA or Fed. R. Civ. P. 11 when a party brings an action in district court, loses on the merits and then for the first time on appeal raises the issue of lack of subject matter jurisdiction.

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I. STATEMENT OF THE CASE

On June 3, 1993, Janette Knudson sued Hyundai Motors of America and others in Superior Court for the County of Los Angeles County, State of California ("Knudson I"). (Pet. 4.)[1] Petitioners Great-West Life & Annuity Insurance Company ("Great-West"), Earth Systems, Inc. ("Earth Systems), and the Health and Welfare Plan for Employees and Dependents of Earth System, Inc. ("the Plan," collectively referred to as "Petitioners") were notified of the lawsuit in 1993. At all times, Petitioners failed to file a lien or become a plaintiff-in-intervention although having statutory rights to do so under California law.

On March 26, 1997, Janette Knudson served Petitioners with a notice of an application for approval of a conditional settlement and for the establishment of a special needs trust and to satisfy the amounts of the liens by the healthcare providers.[2] (Resp. App. A-3a.) The application included the ERISA summary plan description which included the right to recovery provision. Respondent Janette Knudson requested an interpretation of the summary plan description to determine the amount of the lien owed to Great-West. (Pet. B-3) Petitioners did not file a lien, intervene or oppose the state court but instead removed the action to district court. (Pet. App. B-1.)

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1. "Pet." refers to the Petition for Writ of Certiorari. "Pet. App." refers to the Appendix, immediately following the text of the petition. "Resp. App." refers to Respondent Janette Knudson's Appendix attached hereto.

2. The parties stipulated that this application was properly served. The stipulation of facts between the parties is reproduced and attached as Appendix A.

On June 30, 1997, the district court remanded the action entitled, *Great-West Life and Annuity v. Janette Knudson, et al.*, Case No. CV 97-2801 JMI (JGx) ("Knudson II"), advising Great-West that the state court could fairly adjudicate Respondent Janette Knudson's lien obligations. (Resp. App. A-3a.)

On July 3, 1997, Respondent Janette Knudson served both Great-West and Earth Systems with the petition for an order to approve a conditional settlement agreement, order directing the net money to be paid to the Janette Knudson Special Needs Trust, Probate Code § 3611 and for an order approving settlement, including the disbursement for Medi-Cal and other disputed creditors with declarations by Janette Knudson and Jeffrey S. Pop.[3] (Resp. App. A-3a.) Along with this petition was the notice of hearing for July 23, 1997.

On July 8, 1997, Petitioners served Respondent Janette Knudson with its verified first amended complaint in this case, case no. CV 97-3745 JMI (JGx) ("Knudson III"), plus Petitioners' application for a temporary restraining order and other moving papers. (Resp. App. A-4a.)

On July 9, 1997, the district court denied the application for temporary restraining order.[4] (Resp. App. A-4a.) In its ruling, the district court stated:

> Further, Great-West has filed this [a]pplication after failing for three years to intervene in the state court action. Such a glaring omission raises a strong

3. The parties have stipulated that these documents were properly served.

4. The order denying the temporary restraining order is reproduced and attached as Appendix B.

> suspicion that Plaintiffs are forum shopping at the eleventh hour. (Resp. App. B-10a.)

On July 23, 1997, the court reviewed the ERISA plan, including the right to recovery language in the Plan and Great-West's lien claim of $411,152.11. The court evaluated the limited settlement funds in relation to the proportion of the past medicals recovered, the present value of future medical expenses, the past loss of earnings, and the present value of the future loss of earnings as well as the loss of enjoyment of life for the 35 year old, single mother who is quadriplegic and approved Great-West's lien of $13,828.70. (Resp. App. A-4a.) The court adjudicated the issues and compromised the medical lien, finding that the settlement was fair given the complex liability issues which caused Janette Knudson to accept a compromise settlement that only minimally compensated her for her catastrophic injuries. (Resp. App. A-4a.) The court authorized the Janette Knudson Special Needs Trust pursuant to California Probate Code § 3604.

Great-West again failed to file a lien, intervene, or to even appear to oppose the approval of the settlement and the establishment of the Janette Knudson Special Needs Trust and the determination of the medical lien amounts in light of the relatively small settlement.

On August 1, 1997, Janette Knudson served the order upon both Great-West and Earth Systems, trustee for the Plan. (Resp. App. A-5a.) Petitioners failed to appeal. Pursuant to the court order, Janette Knudson transmitted the funds to Great-West on August 21, 1997. (Resp. App. A-5a.) As ordered by the court, Defendant Hyundai directly funded the special needs trust. (Resp. App. A-5a.)

Thereafter, Great-West served its first amended complaint and the underlying district court litigation ensued. On May 14, 1998, after discovery and after numerous motions were argued, the district court granted Janette Knudson's cross-motion for summary judgment based upon its interpretation of the Plan's right to recovery language. (Pet. App. C-10.)

On May 20, 1998, the court entered the written order granting Janette Knudson's motion for summary judgment and statement of uncontroverted facts and conclusions of law. (Pet. App. C-10.) Thereafter, the district court denied Petitioners' motion for reconsideration and granted Janette Knudson's request for attorney fees. (Pet. App. D-1.)

On August 7, 1998, Great-West appealed the granting of summary judgment and request for attorney fees to the United States Court of Appeals for the Ninth Circuit.

On February 7, 2000, the Ninth Circuit Court of Appeals affirmed on different grounds in a non-published decision yet, indicating the appeal could be dismissed on the merits. (Pet. App. A-1.)

Petitioners filed for a petition for writ of certiorari in this Court on May 9, 2000. Janette Knudson now respectfully opposes the petition.

II. STATEMENT OF FACTS

This case involves a lien-holder, Great-West, who after three separate notices, twice by plaintiff and once by the district court, failed to intervene or appear in a state action to assert its lien rights but is now attempting to circumvent the state court's judgment which is now final, and the federal district court's concurrence with the state court's interpretation of the lien language.

Janette Knudson was driving a 1991 Hyundai on June 1992 when the car went off Interstate 5 at seventy (70) miles per hour and rolled over several times. (Pet. App. B-1.) She instantly became a quadriplegic. (Pet. App. A-2.) Janette Knudson is solely responsible for raising her nine (9) year old daughter, Jenna.

The Plan's Right to Recovery provision limited Great-West's lien to amount received for past medical treatment. (Pet. 5.) It states in pertinent parts:

> RIGHT OF RECOVERY. We will, at our sole option, have the right to recover from the covered person any payment for benefits paid for treatment of such loss under this booklet which the covered person is entitled to receive from a third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the covered person receives from:
>
> > The third party; or the third party's insurer or guarantor; or the covered person's uninsured motorists insurance.

This lien will not exceed:

> the amount of benefits paid under this booklet for the treatment of a loss; or
>
> *the amount received by the covered person for such medical treatment from the third party*. . . . (Pet. 5 (emphasis added).)

Both the California state court *and* the district court interpreted this language in support of Janette Knudson's position that the lien amount was limited to the amount received for past medicals. Both courts ruled in Janette Knudson's favor based upon the merits of the case.[5] (Pet. App. C-10.) The district court held that a plan administrator cannot delete a provision of the Plan. (Pet. App. C-9.) Thus, when Great-West ignored the express limit on the recoverable lien, the court held that it acted arbitrarily and capriciously. (Pet. App. C-9.)

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5. During the district court proceedings, neither party mentioned the issue that is now framed by Great-West in this petition.

III. ARGUMENT

A. WHETHER AN ERISA PLAN FIDUCIARY MAY INTERVENE OR FILE A LIEN IN STATE COURT TO ENFORCE ITS RECOUPMENT PROVISION IN ORDER TO AVOID MULTIPLICITY OF ACTIONS.

B. WHETHER AN ERISA PLAN FIDUCIARY SEEKING COLLECTION FROM ITS BENEFICIARY UNDER A RECOUPMENT (SUBROGATION) PROVISION IN THE PLAN MAY IGNORE TIMELY NOTICE OF STATE COURT PROCEEDINGS TO DETERMINE THE AMOUNT OF MONEY AVAILABLE FOR RECOUPMENT AS WELL AS FOR OTHER LIEN-HOLDERS, AND INSTEAD LATER BRING A SEPARATE ACTION AGAINST THE BENEFICIARY IN FEDERAL COURT TO RELITIGATE THE AMOUNT.

This Court should not review the *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997), decision because it was not an issue in this case nor was it raised at the trial level; and it has no effect on this case because *Knudson* was decided on the merits.

This Court normally does not consider issues unless they have been presented to the courts below for decision. The failure to raise an issue in the courts below, absent extraordinary circumstances, precludes its consideration on appeal. *See Sisson v. Ruby*, 497 U.S. 358, 359 n.1 (1990); *Yee v. Escondido*, 503 U.S. 519, 532-33 (1992). In pursuing its claim in district court, Great-West never mentioned *FMC Medical Plan v. Owens*, 122 F.3d 1258, but instead repeatedly asserted that the district court had jurisdiction.

1. There Was A Separate and Independent Basis For The District Court's Grant of Summary Judgment and the Ninth Circuit's Decision In Favor of Janette Knudson.

Summary judgment in favor of Janette Knudson was granted on the merits of the case. The Ninth Circuit noted that "in evaluating the substantive holding . . . requiring the dismissal of reimbursement claims for third party settlements under ERISA, the dismissal could be based either on lack of subject matter jurisdiction or on the *merits*."[6] (Pet. App. A-3 (emphasis added).)

Therefore, independent of the subject matter jurisdiction question, Great-West was not entitled to ignore the terms of the Plan which was properly interpreted by two trial courts.

The Petitioners are inferring that the district court in this case failed to accept subject matter jurisdiction over this ERISA case. They are wrong. The district court granted summary judgment in favor of Respondent Janette Knudson based upon the merits of her case and the interpretation of the ERISA health plan. The same interpretation argument was presented to and adopted by both the state court and district court. Janette Knudson argued that the district court had concurrent subject matter jurisdiction in the case.

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6. In footnote 5 of the Court of Appeals' Memorandum, the court makes reference to *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997). The proper reading of the footnote demonstrates that the Court of Appeals also considered the merits of this case in rending its decision in affirming the district court's decision.

2. *FMC* Is Not At Issue Nor Was It Raised.

As discussed above, Great-West never raised *FMC* during the district court proceedings. Great-West only raised *FMC* on appeal after it lost its case on the merits in district court. It is disingenuous for Great-West which filed the case in federal court and had its day in court to now attempt to avoid paying attorney fees for its miscalculations.

Apparently, since Petitioners have lost, they are now attempting to challenge the holding in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997). This attempt is improper for a few reasons. First, the *FMC* case was never raised by Petitioners at the district court level.

Second, there are other cases before this Court which would may cleanly resolve this relatively "benign" issue. *See, e.g., Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 2000), *petition for cert. filed*, 68 U.S.L.A. 3713 (U.S. May 10, 2000) (No. 99-1787); *Cement Masons Health and Welfare Trust Fund for Northern California v. Stone*, 197 F.3d 1003 (9th Cir. 1999), *petition for cert. filed*, 68 U.S.L.W. 3566 (U.S. Feb. 22, 2000) (No. 99-1403).

In *Reynolds*, 202 F.3d at 1247, and *Cement Masons*, 197 F.3d at 1005, the plan or its insurer filed in federal court seeking reimbursement for medical expenses which the plan or insurer had paid. Prior to the filing of the lawsuits, there had been no judicial determination of the amount of the recoverable lien. In those cases, the Respondent did not recognize the lien.

In the instant case, the state court determined the amount of the recoverable lien according to the principles set forth in ERISA. Great-West had standing to appear at the state court hearing and was repeatedly urged to attend. It chose not to participate. The language of the Plan limited the amount of recovery.

In *Reynolds*, 202 F.3d at 1248, and *Cement Masons*, 197 F.3d at 1006-09, the plan participants defended against the claim for reimbursement by asserting *FMC* against the Plan/ insurers' federal court claim for reimbursement.

Janette Knudson has never asserted the lack of subject matter jurisdiction issue. In this case, on appeal, but not raised below, Petitioners for the first time asserted *FMC* against itself in order to avoid the imposition of attorney fees. The appellate decision affirmed the granting of summary judgment on separate and independent grounds for which the trial court granted summary judgment, but noted that this case was summarily resolved based upon the merits.

Unlike *Reynolds* and *Cement Masons*, Janette Knudson acknowledged and recognized the Plan's right to recovery. Janette Knudson paid Great-West pursuant to a court order. In this case, the alleged fiduciaries had ample opportunities to intervene in a state action *before* an adjudication of the amount of liens, but failed to do so.

Third, even assuming that somehow this issue merits review by this Court, the outcome in Janette Knudson's case remains unchanged because both the state and federal court found in her favor based upon the merits of her case and the interpretation of the language of the Plan which limited recovery to the amount of past medical expenses received from a tortfeasor.

C. WHETHER A COURT MAY AWARD ATTORNEY'S FEES UNDER EITHER ERISA OR FED. R. CIV. P. 11 WHEN A PARTY BRINGS AN ACTION IN DISTRICT COURT, LOSES ON THE MERITS AND THEN FOR THE FIRST TIME ON APPEAL RAISES THE ISSUE OF LACK OF SUBJECT MATTER JURISDICTION.

It is within the court's discretion to award attorney's fees. *See* 29 U.S.C. § 1132(g)(1). Great-West has not argued that the district court abused its discretion under ERISA, and thus, there is no basis to reverse or modify the award of attorney's fees.

In *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 409 (1990), this Court held that district courts retain jurisdiction to award attorney's fees pursuant to Fed. R. Civ. P. 11 after a voluntary dismissal of the suit. This Court stated:

> It is well established that a federal court may consider collateral issues after an action is no longer pending. For example, district courts may award costs after an action is dismissed for want of jurisdiction. *See* 28 U.S.C. § 1919. This Court has indicated that motions for costs or attorney's fees are "independent proceedings supplemental to the original proceeding and not a request for a modification of the original decree." *Sprague v. Ticonic National Bank*, 307 U.S. 161, 170 (1939). Thus, even "years after the entry of a judgment on the merits" a federal court could consider an award of counsel fees. *White v. New Hampshire Dept. of Employment Security*, 455 U.S. 445, 451, n.13 (1982). A criminal contempt charge is

likewise " 'a separate and independent proceeding at law' " that is not part of the original action. *Bray v. United States*, 423 U.S. 73, 75 (1975), *quoting Gompers v. Bucks Stove & Range Co.*, 221 U.S. 418, 445 (1911). A court may make an adjudication of contempt and impose a contempt sanction even after the action in which the contempt arose has been terminated. *See United States v. Mine Workers*, 330 U.S. 258, 294 (1947) ("Violations of an order are punishable as criminal contempt even though . . . the basic action has become moot"); *Gompers v. Bucks Stove & Range Co.*, *supra*, 451 (when main case was settled, action became moot, "of course without prejudice to the power and right of the court to punish for contempt by proper proceedings"). Like the imposition of costs, attorney's fees, and contempt sanctions, the imposition of a Rule 11 sanction is not a judgment on the merits of an action. Rather, it requires the determination of a collateral issue: whether the attorney has abused the judicial process, and, if so, what sanction would be appropriate. Such a determination may be made after the principal suit has been terminated.

Id. at 395-96. *See also Willy v. Coastal Corp.*, 503 U.S. 131, 134-35 (1992) (award of attorney's fees pursuant to Rule 11 permissible following an improper removal and remand); *White v. New Hampshire Dept. of Employment Sec.*, 455 U.S. 445, 451-52 (1982) (award of attorney's fees under 42 U.S.C. § 1988 is collateral to decision on the merits, and thus not subject to the 10-day limitation of a motion to amend or alter a judgment); *Moore v. Permanente Med. Group, Inc.*,

981 F.2d 443, 445 (9th Cir. 1992) (district court has power to award attorneys fees even in the absence of subject matter jurisdiction).

Therefore, the question of attorney's fees is well settled and does not need to be reviewed by this Court.

CONCLUSION

For the foregoing reasons, Respondent Janette Knudson respectfully request that this Honorable Court deny the Petition.

Respectfully submitted,

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

Attorneys for Respondent Janette Knudson

APPENDIX

APPENDIX A — STIPULATION OF FACTS BETWEEN THE PARTIES DATED FEBRUARY 9, 1998

Thomas H. Lawrence, TN Bar No. 17105
OGLETREE, DEAKINS, NASH, SMOAK
& STEWART, P.C.
SunTrust Center, Suite 800
424 Church Street
Nashville, TN 75201-7812
(615) 254-1900, (615) 254-1908 fax

Attorneys for Plaintiffs
Great-West Life & Annuity Insurance Company, the Health and Welfare Plan for Employees of Earth Systems, Inc., and and Earth Systems, Inc., the Plan Administrator for the Health and Welfare Plan for Employees of Earth Systems, Inc.

JEFFREY S. POP & ASSOCIATES
Jeffrey S. Pop, Esquire - State Bar #054343
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462, (310) 274-7749 fax

Attorneys for Defendant
Janette Knudson

Appendix A

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV-97-3745 JMI (Jgx)

STIPULATION OF FACTS BETWEEN THE PARTIES

(Judge James M. Ideman)

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC.

Plaintiffs,

v.

JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual

Defendants.

Thomas H. Lawrence, Esquire on behalf of GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYERS OF EARTH SYSTEMS, INC. AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYERS OF EARTH SYSTEMS, INC., Plaintiffs and Jeffrey S. Pop, Esquire on behalf of JANETTE KNUDSON, Defendant, hereby stipulate to the following facts which are *not* disputed:

Appendix A

1. On March 26, 1997, Jeffrey S. Pop, on behalf of Janette Knudson, sent by mail a document entitled "NOTICE OF MOTION AND MOTION TO APPROVE SETTLEMENT AND PETITION FOR ORDER DIRECTING THE NET MONEY TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE CODE* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDICAL AND OTHER DISPUTED CREDITORS; DECLARATION OF JANETTE KNUDSON AND JEFFREY S. POP ATTACHED HERETO; POINTS AND AUTHORITIES; EXHIBIT 11; AND [PROPOSED] ORDER FILED SEPARATELY AND CONCURRENTLY HEREWITH". The foregoing document was received by mail and/or Express Mail by Great-West Life & Annuity Insurance Company ("Great West"). The Notice of Motion stated that the hearing date for the Motion was April 23, 1997 in Superior Court;

2. On April 22, 1997, Great-West filed a Notice of Filing Notice of Removal in State Court and a Notice of Removal in Federal Court and thereby removed the action to Federal District Court in Case No. CV 97-2801-JMI (Anx);

3. On June 30, 1997, the Order granting Plaintiff's Motion to Remand and Order Remanding Action to Superior Court was filed by the United States District Judge, James M. Ideman;

4. On July 3, 1997, Plaintiff Janette Knudson re-noticed and filed in Superior Court, Case No. LC 022329 a "NOTICE OF MOTION AND MOTION TO APPROVE SETTLEMENT AND PETITION FOR ORDER DIRECTING THE NET

MONEY TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE COURT* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDICAL AND OTHER DISPUTED CREDITORS; POINTS AND AUTHORITIES IN SUPPORT THEREIN; DECLARATION OF JEFFREY S. POP IN SUPPORT THEREOF." The Notice of Motion stated that the hearing date was July 23, 1997. The foregoing documents were mailed to, and received by, both Great-West and Earth Systems, Inc.

5. On or about July 8, 1997, Great-West Life and Earth Systems, Inc., Plaintiffs, made an Ex Parte Application for Temporary Restraining Order in Case No. CV 97-3745 JMI (Jgx) and served the Verified First Amended Complaint on Janette Knudson and her attorney, Jeffrey S. Pop, along with the Ex Parte Application for Temporary Restraining Order;

6. On July 9, 1997, James M. Ideman, United States District Judge, issued an Order denying Plaintiff's Ex Parte Application for Temporary Restraining Order in Case No. 97-3745 JMI (Jgx);

7. On July 23, 1997, Judge Farrell issued an ORDER APPROVING SETTLEMENT AND PETITION DIRECTING THE NET MONIES TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE CODE* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDICAL AND OTHER DISPUTED CREDITORS;

8. On August 1, 1997, the ORDER APPROVING THE SETTLEMENT AND THE ESTABLISHMENT OF THE JANETTE KNUDSON SPECIAL NEEDS TRUST was mailed to, and received by, both Earth Systems, Inc. and attorneys for Great-West.

9. On August 21, 1997, by letter to Great-West, Assistant Recovery Manager, Louis A. Tuccitto, Pop issued a client's trust check in the amount of Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) to Great-West. A carbon copy of the letter was sent to and received by counsel for Plaintiffs.

10. On August 22, 1997, Attorney Lawrence faxed to Attorney Pop a letter notifying him that all funds should be segregated pending the outcome of the Federal Court case.

11. On August 22, 1997, Attorney Pop faxed and mailed a letter to Attorney Lawrence informing him that the monies Attorney Pop received had been disbursed and the Special Needs Trust was funded directly from Hyundai.

The foregoing facts as to the timing of events are undisputed and hereby stipulated to by the parties.

Dated: February 9, 1998

JEFFREY S. POP & ASSOCIATES

By */s/* _____
Jeffrey S. Pop, Esq.
Attorneys for Defendant
Janette Knudson

Appendix A

Dated: February 9, 1998

OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.

By */s/* _____
Thomas H. Lawrence, Esq.
Attorneys for Plaintiffs
GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY, ET AL.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA DENYING PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER DATED JULY 9, 1997

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV-97-3745 JMI (JGx)

GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY, et al.,

Plaintiffs,

v.

JANETTE KNUDSON, et al.,

Defendants.

ORDER DENYING PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER

IT IS HEREBY ORDERED:

This Court is in receipt of Plaintiffs' *ex parte* Application for a Temporary Restraining Order. This Court is also in receipt of Defendants' Oppositions. After careful review, considering all the arguments and materials presented by the parties, the Application is hereby DENIED.

Appendix B

BACKGROUND

This action arises under the Employee Retirement Income Security Act of 1974 ("E.R.I.S.A."), codified at 29 U.S.C. § 1001, *et seq.* Plaintiff Great-West Life & Annuity Insurance Company ("Great-West") is the assignee for collection of the health and welfare plan for employees of Earth Systems, Inc. ("Earth Systems"). Defendants are Janette and Eric Knudson, husband and wife. Mr. Knudson was an employee of Earth Systems when he and his wife were involved in an automobile accident which left Mrs. Knudson a quadriplegic for life.

Defendants in 1993 sued Hyundai Motors of America, and others, in Los Angeles Superior Court. Though Plaintiff Great-West was the assignee with rights of subrogation on an E.R.I.S.A. funded policy, it did not until recently seek to intervene in that action. Instead, when the Knudsons and Hyundai agreed on a $650,000.00 settlement, Great-West removed that case to federal court (*Knudson, et al. v. Hyundai Motors of America, Inc., et al.*, CV 97-2801 (JMI (ANx)). This Court recently remanded that case because Great-West, a non-party in that action, had no right to remove the case to federal court.

At about the same time, Plaintiffs filed the instant action. They have now applied for a Temporary Restraining Order, asking this Court to enjoin the state court from approving the settlement agreement and enjoining Defendants from receiving any settlement funds. Plaintiff Great-West alleges that it is entitled to $411,157.11 of the settlement proceeds because it paid out that amount in plan benefits to pay for

Appendix B

Defendants' medical expenses. Because the E.R.I.S.A. plan provided for first-lien reimbursement of medical expenses recovered from third parties, Plaintiff Great-West argues that it is entitled to injunctive relief.

ANALYSIS

Interlocutory injunctive relief is appropriate if the moving party can show either: (1) a likelihood of success on the merits and the possibility of irreparable injury; or (2) that serious questions exist on the merits and the balance of hardships tips sharply in its favor. *Associated Gen. Contractors of Cal. v. Coalition for Economic Equity*, 950 F.2d 1401, 1410 (9th Cir. 1991). Alternatively, a court may issue an injunction if it finds: (1) a strong likelihood of success on the merits; (2) a possibility of irreparable injury to the moving party; (3) that the balance of hardships favors the moving party; and (4) in certain cases, that the public interest favors injunctive relief. *Johnson v. California State Bd. of Accountancy*, 72 F.3d 1427, 1430 (9th Cir. 1995).

In this case, injunctive relief is not appropriate. It is well settled that a federal court may not enjoin a state court proceeding "except as expressly authorized by Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments." 28 U.S.C. § 2283. This rule codifies the general rule of restraint in cases such as this, where an unnecessary injunction against a separate sovereign promises to disrupt the delicate balance of federalism. In this case, Plaintiffs have made no showing that there exists any of the three narrow exceptions mandated by statute. For that reason alone, the Application must fail.

Appendix B

Also, it appears that Plaintiff is not likely to succeed on the merits. The settlement agreement, which promises to provide $650,000.00 to the Knudsons, allocates damages as follows:

Loss of Earnings	5%
Past Medical Expense	5%
Future Medical Expenses	45%
Loss of Enjoyment of Life; Distress; Long-Term Disability	40%
Other	5%

Because past medical expenses reflect only five per cent of the proposed settlement amount, it does not appear that Plaintiff Great-West will be entitled to full subrogation. Rather, it appears that Great-West will ultimately recover far less than the amount it seeks here.

Two more reasons support denial of Plaintiffs' Application. Plaintiffs have not alleged irreparable harm, as their rights of subrogation remain intact, leaving them an adequate legal remedy to recover what they are rightly due once the settlement is paid. Further, Great-West has filed this Application after failing for three years to intervene in the state court action. Such a glaring omission raises a strong suspicion that Plaintiffs are forum shopping at the eleventh hour.

Appendix B

CONCLUSION

Accordingly, Plaintiff's Application is hereby DENIED.

IT IS SO ORDERED.

DATED: July 9, 1997

/s/ _____
James M. Ideman
United States District Judge

Mar 5, 2001 (7)

Supreme Court, U.S.
FILED
MAR 5 2001
CLERK

No. 99-1786

In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITIONERS' OPPOSITION TO RESPONDENTS' MOTION TO DISMISS AS IMPROVIDENTLY GRANTED

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, D.C. 20007
(202) 965-8100

THOMAS H. LAWRENCE
HALE HEADRICK DEWEY WOLF GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

Counsel for Petitioners

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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BACKGROUND AND COUNTERSTATEMENT OF THE CASE

In July, 1997, Petitioners filed the present action against Respondents (the "Knudsons") in the United States District Court for the Central District of California alleging a claim under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Petitioners sought to recoup, from Respondents' state-court third-party tortfeasor recovery, $411,157.11 in medical benefits that they had advanced to Respondents.[1] After the parties filed cross-motions for summary judgment, the district court granted summary judgment in favor of the Knudsons, awarding Petitioners only $13,828.70 (5% of the settlement less attorney's fees), the amount which Respondents' state-court settlement had allocated to medical expenses.[2] (Order Granting Defendants' Motion For Summary Judgment, Pet. App. C-1.) The district court also awarded the Knudsons $80,497.50 in attorney's fees pursuant to 29 U.S.C. § 1132(g)(1).

Petitioners appealed to the Ninth Circuit, asserting that multiple errors required that the district court's decision be reversed and judgment entered in their favor. Petitioners also asserted that the federal court had subject matter jurisdiction over their reimbursement action, notwithstanding the recent decision of the Ninth Circuit in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997), to the contrary. Without considering the district court's basis for its decision, the Ninth Circuit declined the invitation to overturn *Owens*, after which this Court, by

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[1] The ERISA plan provided for first-lien reimbursement of medical expenses recovered from third parties. (Pet. App. C-3.)

[2] Petitioners were not parties to the state-court action.

Order dated January 22, 2001, granted certiorari to resolve a conflict among the federal courts of appeal.

Respondents have moved to dismiss as improvident the Court's grant of certiorari, asserting "there is no case or controversy." (Respondents' Mot. at 1.)[3] Knudsons' arguments fall into two categories: the first being jurisdictional arguments that the Court lacks the "power to hear this case," and the second being merits arguments stressing (in agreement with Petitioners) that § 502(a)(3) of ERISA provides Petitioners with the very cause of action that the Ninth Circuit rejected. Before reaching those arguments, however, Petitioners will address two misstatements by the Knudsons regarding the Ninth Circuit proceedings, as those misstatements infect virtually all of the Respondents' legal arguments.

Foremost of these misstatements is the Knudsons' contention that the Ninth Circuit issued what would amount to an advisory opinion by deciding not only that no ERISA § 502(a)(3) claim was available to Petitioners, but also actually affirmed the district court's reasoning on the merits of that claim. The Knudsons reason that if this is so, then this Court's ruling on the existence of a claim

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[3] Supreme Court Rule 15.4 provides that "[a]ny objections to the jurisdiction of the Court to grant a petition for a writ of certiorari shall be included in the brief in opposition [to a petition for a writ of certiorari]." Respondents, in fact, in opposing certiorari previously argued there was no "case or controversy" between the parties. (Appellee Janette Knudson's Answering Br. at 40-41.) Knudsons' Motion, which rehashes and expands on that argument, while adding nothing that could not have been earlier addressed, in essence disregards Rule 15.4 and wastes both the Court's and the parties' resources.

under § 502(a)(3) is superfluous to the ultimate outcome, because the Ninth Circuit's "merits determination" would in any event resolve the case. This contention badly misinterprets the Ninth Circuit's holding. The Ninth Circuit expressly did not review the substantive merits of the district court's decision.

Although the district court did grant summary judgment on the merits of Petitioners' § 502(a)(3) claim, the Ninth Circuit carefully avoided addressing the multiple grounds of error that Petitioners advanced on appeal for reversal of summary judgment.[4] Instead the court stated: "We affirm the district court's judgment ***but do so on grounds different from those relied on by the district court.***" (Pet. App. A-2 (emphasis added).) The ***only*** ground that it then gave for its affirmance was its holding in *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1262 (9th Cir. 1997), that a claim for reimbursement of payments made to a plan beneficiary by a third party is not equitable relief under § 502(a)(3). (Pet. App. A-3, 4.) In so holding, the Ninth Circuit, in footnote 5 of its memorandum opinion, addressed a point at the root of Respondents' contention that the Ninth Circuit decided "the merits" of Petitioners' § 502(a)(3) claim:

> *Owens* rests its dismissal on the lack of subject matter jurisdiction. *But see Cement Masons Health and Welfare Trust Fund for Northern California v. Stone*, 197 F.3d 1003, 1008 (9th Cir. 1999) (reaffirming the substantive holding in *Owens*

---

[4] Review of the district court's summary judgment decision would have been governed by a *de novo* standard. *Barnes v. Independent Automobile Dealers Assoc. of Cal. Health & Ben. Plan*, 64 F.3d 1389 (9th Cir. 1995).

> but dismissing on the merits rather than on subject matter jurisdiction). For our purposes, in evaluating the substantive holding of *Owens* requiring the dismissal of reimbursement claims for third party settlements under ERISA, ***the dismissal could be based either on lack of subject matter jurisdiction or on the merits.***

(Pet. App. A-4 (emphasis added).)

On its face, this language reflects that the Ninth Circuit was stating nothing more than that its holding in *Owens*, which rejects the availability of a § 502(a)(3) claim for reimbursement, could be viewed as a dismissal on either a jurisdictional basis under Rule 12(b)(1), Fed.R.Civ.P., or on a "merits" basis for failure to state a claim for relief under Rule 12(b)(6), Fed.R.Civ.P. This is the very point for which *Cement Masons* is cited. The term "merits" as used in footnote 5 does not refer to the substantive issues of the case. Rather, it refers only to whether a claim had been stated upon which relief could be granted. Moreover, the identical footnote, authored by the same panel as here, is found in *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1248 n.2 (9th Cir. 2000). In *Ellis*, however, because the district court dismissed the case on a pre-answer motion (on the basis of *Owens*), there was no substantive merits determination that the Ninth Circuit was even asked to address. Accordingly, its statement in *Ellis* that "the dismissal could be based either on lack of subject matter jurisdiction or on the merits" necessarily refers solely to the resolution of the legal issue of whether a claim was available under ERISA. The panel's use of the identical language in *Knudson*, therefore, can

hardly be taken as reflecting an entirely different analysis – i.e., addressing the substance of the § 502(a)(3) claim.

Respondents also suggest that Petitioners' raising of the *Owens* decision in the Ninth Circuit was somehow inappropriate. (Mot. at 4.) As the Knudsons concede, however, Petitioners raised *Owens* (as they were obliged to do) in attempting to persuade the Ninth Circuit to permit Petitioners to ***enforce*** their claim for reimbursement under § 502(a)(3). (Mot. at 2.) The suggestion that this unsuccessful entreaty to the Ninth Circuit somehow precludes Petitioners from seeking this Court's review of the Ninth Circuit's denial is nonsensical.[5]

In summary, Petitioners seek a reversal in this Court on the issue presented in order to have the Ninth Circuit address the merits of the district court's decision – something it did ***not*** do.

---

[5] Respondents boldly assert what the position of the United States Solicitor General would have been had Respondents earlier declared they would not change sides on the issue before the Court. (Mot. at 2-3.) Aside from being speculation, as demonstrated *infra* at Argument I, there is no constitutional reason why Respondents' decision not to file an opposing brief would deprive this Court of the ability to resolve the conflict in the courts of appeal presented in this case.

ARGUMENT

I.

THIS ACTION UNQUESTIONABLY PRESENTS A CASE OR CONTROVERSY WHERE THIS COURT'S DECISION WILL HAVE REAL MEANING TO THE RESOLUTION OF A DISPUTED ASSERTION OF RIGHTS BY PETITIONERS

Respondents confuse the parties' lack of *dis*agreement on an issue as to which the federal courts of appeal are in conflict (and as to which this Court granted certiorari) with the lack of agreement over how the action should be finally resolved on the merits. True enough, both parties agree that the Ninth Circuit should have recognized Petitioners' right to bring a claim for relief under ERISA § 502(a)(3). Respondents' "stipulation" that the federal court had jurisdiction does not resolve this issue. The federal courts (and not the parties) have the right and obligation to determine whether they have been authorized to hear a case.

In this case, the Ninth Circuit's ruling bars the federal courthouse doors to such claims, depriving Petitioners of a federal right that Congress granted exclusive jurisdiction to the federal courts to hear. ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1). The state court result orchestrated by the Knudsons thus has been allowed to trump Petitioners' federal rights. Given this outcome in the Knudsons' favor, it is hardly surprising that they now concede that it would be contrary to their interests to support the grant of certiorari in this case (Mot. at 5), because certiorari is the only avenue for Petitioners to obtain redress under ERISA and reverse the outcome in the lower courts.

The Court has repeatedly recognized that agreement on the issue before it does not deprive the suit of Article III justiciability. For instance, in *Cardinal Chemical Co. v. Morton International, Inc.*, 508 U.S. 83, 88 n.9 (1993), the Court examined a practice of the Federal Circuit that prevented the Federal Circuit from reaching the underlying dispute regarding the validity of patents. Despite the parties' agreement that the Federal Circuit's position was wrong, the Court recognized that Article III concerns had been satisfied. *See also id.* at 104 (Scalia, J., concurring) ("I agree . . . that the parties' total agreement as to disposition of this case poses no constitutional barrier to its resolution."). The same situation presents itself here. Both sides agree that the Ninth Circuit should have recognized Petitioners' right to sue under § 502(a)(3). The Ninth Circuit's own position, however, prevented it from resolving the underlying dispute – i.e., whether Petitioners have enforceable federal rights that grant them a recovery other than that decided in the state court action in which Petitioners were not parties.[6]

This Court's ruling in *United States National Bank of Oregon v. Independent Insurance Agents of America, Inc.*, 508 U.S. 439 (1993), provides analogous support. There, the

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[6] The authority Respondents cite for their contention that their strategic choice not to file an opposing brief deprives this Court of the power to hear this matter is inapposite. For instance, one cannot question whether this matter is here as a result of collusion. *See, e.g., Cleveland v. Chamberlain*, 66 U.S. 419 (1861). Nor is this a scenario where one party has in the course of litigation acquired a controlling interest in its adversary. *See, e.g., South Spring Hill Gold Min. Co. v. Amador Medean Gold Min. Co.*, 145 U.S. 300 (1892).

Court recognized that the court of appeals had not been deprived of the constitutional power to determine the validity of an omitted section of the United States Code (section 92) even though section 92's validity had not been challenged despite the court of appeals having ordered supplemental briefing. *See id.* at 446. In rejecting the proposition that there was no case or controversy presented to the court of appeals about the validity of section 92, this Court emphasized that "from the start respondents' suit was the 'pursuance of an honest and actual antagonistic assertion of rights by one [party] against another,' that 'valuable legal rights . . . [would] be directly affected to a specific and substantial degree' by a decision on whether the Comptroller's ruling was proper and lawful, and that the Court of Appeals therefore had before it a real case and controversy extending to that issue." *Id.* at 446 (quoting *Muskrat v. United States*, 219 U.S. 346, 359 (1911)) (second alteration in original).

The Knudsons' attempt to distinguish *Bank of Oregon* is spurious. First, Respondents argue that the Ninth Circuit affirmed the "merits" of the lower court's judgment, which is simply not the case. (Mot. at 8.) Second, Respondents assert that "no meritable counter-argument" supports the Ninth Circuit's rejection of a claim for reimbursement under ERISA § 502(a)(3). *Id.* Castigating the Ninth Circuit's position that § 502(a)(3) does not provide Petitioners a cause of action for reimbursement should not immunize that very decision from this Court's review.

The Court, when recognizing that the agreement of the parties before it poses no constitutional barrier to resolution of an issue, has been prompted by prudential

concerns on at least some of those occasions to appoint *amici* to argue the unrepresented side of an issue. *See, e.g., Toibb v. Radloff*, 501 U.S. 151 (1991) (private member of bar appointed as *amicus curiae* to defend judgment of Court of Appeals after United States Trustee indicated his agreement with petitioner's position). While Petitioners believe that such a step is unnecessary for the Court to consider fully the merits of the issue on which certiorari has been granted, they respectfully urge the Court to appoint an *amicus* to argue the unrepresented side, if the alternative is dismissal of certiorari.

II.

RESPONDENTS' ARGUMENTS REGARDING THE AVAILABILITY OF A CLAIM FOR REIMBURSEMENT UNDER ERISA DO NOT COUNSEL AGAINST THIS COURT'S REVIEW OF THE NINTH CIRCUIT DECISION AT ODDS WITH THOSE ARGUMENTS

The Respondents also make a number of arguments that essentially conclude that the Ninth Circuit's decision in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997), is without merit.[7] (Mot. at Argument II, pp. 9-12.) As the rationale of that holding is precisely the issue raised in the question upon which certiorari has been granted, the Knudsons' firm conviction is all the more reason why the conflict in the courts of appeal created by *Owens* should be promptly resolved. As demonstrated

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[7] These merits arguments should be deemed waived by not having been raised in the Knudsons' opposition to certiorari. Supreme Court Rule 15.4.

above, and as determined in the grant of certiorari, this is clearly an appropriate case for so doing.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that the Court deny Respondents' motion to dismiss the grant of certiorari as improvident.

Respectfully submitted,

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, DC 20007
(202) 965-8100

THOMAS H. LAWRENCE
HALE HEADRICK DEWEY WOLF
GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

Counsel for Petitioners Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc.

(5)

Supreme Court, U.S.
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No. 99-1786

In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

SUPPLEMENTAL BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

THOMAS H. LAWRENCE
Counsel of Record
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

2PP

SUPPLEMENTAL BRIEF

Pursuant to Rule 15 of the Supreme Court Rules, Petitioners present this supplemental brief in support of their petition for a *writ of certiorari* to advise the Court that there are two other cases pending for decision on petitions for *writs of certiorari* that present the identical issue presented by this petition: *Cement Masons Health and Welfare Trust Fund for Northern California v. Stone*, No. 99-1403 and *Reynolds Metals Co. v. Ellis*, No. 99-1787. If the Court grants either of these petitions, Petitioners respectfully request that the Court either consider this case along with the case on which the court grants *certiorari* or hold this case pending resolution of that case.

Respectfully submitted,

THOMAS H. LAWRENCE
Counsel of Record for Petitioners

HALE HEADRICK DEWEY WOLF GOLWEN
THORNTON & CHANCE
1727 Kirby Parkway, Suite 150
Memphis, Tennessee 38120
(901) 888-4006

Dated: September 21, 2000.

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GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION TO DISMISS AS IMPROVIDENTLY GRANTED

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

Attorneys for Respondent Janette Knudson

165405

Counsel Press LLC
(800) 274-3321 • (800) 359-6859

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PURPOSE OF MOTION TO DISMISS

Defendant/Respondent Janette Knudson ("Knudson") brings this motion to dismiss on grounds that certiorari was improvidently granted because there is no case or controversy. All parties to this case agree that a claim for reimbursement of medical benefits paid pursuant to a healthcare plan is governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. ("ERISA"), and not by state contract law. (Pet. App. C-5.)[1] In applying ERISA to the interpretation of the healthcare plan, the district court found for Knudson.[2] (Pet. App. C-12.)

STATEMENT OF THE CASE

Plaintiff/Petitioner Great West ("Petitioner") filed an action under ERISA in order to obtain a judicial determination of the plan's rights and Knudson's duties with respect to the reimbursement clauses of the Earth Systems ERISA Plan. (Appellant's ER, Doc. 5, Nos. 1-4, First Am. Compl. ¶¶ 5, 10.) Knudson did not challenge the applicability of ERISA, but rather claimed that Petitioner waived its rights by failing to follow the district court's ruling to attend a

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1. "Pet." refers to the Petition for Writ of Certiorari. "Pet. App." refers to the Appendix in the Pet. "Resp. App." refers to the Appendix in Brief in Opposition for Respondent Janette Knudson. "ER" refers to the Excerpts of Records filed with the Ninth Circuit. "Doc." refers to the docket number used in the ER. "No." or "Nos." refers to the page number(s) of the document.

2. The issue of lack of subject matter jurisdiction was not raised, adopted or argued by Knudson. The choice of law issue is not in dispute since federal law was applied by the district court in the underlying case.

hearing wherein the reimbursement lien was adjudicated pursuant to ERISA. (Appellee's ER, Doc. 13, Nos. 6-12, Answer to First Am. Compl.)

The district court granted Knudson's summary judgment motion, holding that as a matter of law Petitioner's interpretation of the ERISA plan was arbitrary and capricious. (Pet. App. C-9.) Petitioner appealed to the Ninth Circuit. (Pet. 2.)

On appeal, Petitioner for the first time interjected the issue whether a claim for reimbursement pursuant to an ERISA plan may be brought under ERISA. (Knudson's Ninth Circuit Answering Brief, pgs. 39-46.) Petitioner argued that ERISA was applicable to a claim for reimbursement. (Petitioner's Ninth Circuit Opening Brief, pg. 16, Issue No. 1.) Knudson agreed that ERISA and ERISA case law were applicable and advised the Ninth Circuit that there was "no case or controversy" between the parties on this issue. (Knudson's Ninth Circuit Answering Brief, pgs. 40-41.) However, the Ninth Circuit's unpublished opinion found no ERISA jurisdiction, but nevertheless affirmed the district court's ruling on the merits. (Pet. App. A-4.)

Petitioner then sought a writ of certiorari for the issue whether enforcing a recoupment of benefits is within the meaning of compensatory damages as set forth in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993). (Pet. I.) On January 22, 2001, this Court granted certiorari. __ U.S. __, 121 S. Ct. 876, 2001 U.S. LEXIS 945.

Subsequent to this Court's grant of the writ of certiorari, Knudson learned that the Solicitor General's Office would not have advised the granting of certiorari had it realized

that all Petitioners, all amicus curiae and Knudson would all argue in favor of applying ERISA law to a claim for reimbursement and none would argue against it.

ARGUMENT

I.

THIS COURT LACKS THE POWER TO HEAR THIS CASE BECAUSE THERE IS NO CASE OR CONTROVERSY BETWEEN PETITIONER AND KNUDSON ON THE APPLICABILITY OF ERISA.

A. The Constitution Requires A Bona Fide Case and Controversy Which Does Not Exist in this Case.

Article III, section 2 of the United States Constitution requires there be a case and controversy. Without a controversy between opposing parties, there is no jurisdiction to hear the issue. U.S. Const., art. III, § 2. This threshold issue must first be determined before this Court can address the question presented. As Justice Stone states in *Nashville, Chattanooga & St. Louis R.R. Co. v. Wallace, Comptroller of the Treasury of Tenn.*, 288 U.S. 249, 263 (1932):

> This preliminary question . . . must first be considered, for the judicial power with which this Court is invested by Art. 3, § 1 of the Constitution, extends by Art. 3, § 2, only to "cases" and "controversies"; if no "case" or "controversy" is presented for decision, we are without power to review the decree of the court below.

Id., citing *Muskrat v. United States*, 219 U.S. 346 (1911). Thus, "the exercise of judicial power under Art. III of the Constitution depends upon the existence of a case or controversy." *Preiser, Commissioner of Correctional Services of New York v. Newkirk*, 422 U.S. 395, 401 (1975).

B. There Is No Case Or Controversy Between Petitioner and Knudson.

Here, because Petitioner and Knudson have always agreed that a claim for reimbursement is covered by ERISA, and that ERISA preempts substantive state law regarding plan interpretation there is no case or controversy between the parties on this issue. (Pet. App. C-5.) The procedural history reveals this fact. Petitioner filed a complaint under ERISA. Knudson answered. The district court applied ERISA law in interpreting the plan's reimbursement provision and found Petitioner's interpretation of the plan was arbitrary and capricious. The district court granted summary judgment in favor of Knudson, and awarded fees and costs against Petitioner pursuant to ERISA.

Petitioner on appeal only then interjected the *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997) case which was not properly raised below. Knudson objected. (Knudson's Ninth Circuit Answering Brief, pgs. 39-46.) It was Petitioner who filed the complaint *under* ERISA, and it was Petitioner and Knudson who *argued for* the applicability of ERISA at the district court level. The district court applied ERISA in its ruling. There is no factual or legal basis for Petitioner to challenge the holding in *FMC* which has nothing to do with this case, because here, the district court applied ERISA. The Ninth Circuit affirmed the district court's judgment on the merits even though dismissal could

have been based upon the lack of subject matter jurisdiction. (Pet. App. A-4 n.5.) There is no case or controversy presented. In fact the district court's ruling was affirmed. (Pet. App. A-4.)

C. Knudson Will Not Argue Against Her Own Interests.

Knudson will not argue for a position which is contrary to her own interests. Knudson obtained a summary judgment motion and attorney fees by applying ERISA law correctly. In the same case she will not argue against her own interests and undermine her victory. Knudson cannot be forced to take a position which would destroy the jurisdictional basis of her district court victory. Further, her attorneys would face a conflict of interest for recognizing the plan's recovery right under ERISA law and by paying the adjudicated lien rights to the plan.

This case does not provide the foundational basis for adjudicating the apparent subject matter jurisdictional split between the Ninth Circuit and the other circuits. The issue was not litigated in the underlying case. This is not the case of a so called "double recovery" by a plaintiff or the case where the plan beneficiary failed to notice the plan administrator before adjudicating the amount of payment to the plan utilizing federal ERISA law.

D. The Law Forbids a Party to Feign a Position In Order to Obtain an Advisory Opinion.

The law does not allow Knudson to create a **collusive case**[3] wherein she argues a position in order to obtain an

3. *See Poe v. Ullman*, 367 U.S. 497, 504 (1961) (collusive suits as meaning actions where there is a want of truly adversary contest with respect to the issue); *see also Cleveland v. Chamberlain*, 66 U.S. 419, 425-26 (1861); *Wood-Paper Co. v. Heft*, 75 U.S. 333, 336 (1868).

advisory opinion. *South Springs Hill Gold Mining Co. v. Amador Medean Gold Mining Co.*, 145 U.S. 300, 301-02 (1892) ("We assumed that this is not an agreed case gotten up by collusion; but the litigation has ceased to be between adverse parties, and the case therefore falls within the rule applied where the controversy is not a real one.")

A collusive case is when one party pretends to set forth a particular position in order to manufacture a controversy. By this ruse, the parties trick a court into issuing an advisory opinion. *Respondent Knudson will not change her position and argue against ERISA*, in order to make this Court believe that a *bona fide* dispute exists between the parties in this case.[4]

E. Petitioner's Argument That ERISA Law Applies When Interpreting a Plan's Provision Supports Affirming the District Court's Granting of Summary Judgment.

Petitioner now argues in favor of an ERISA cause of action which would result in an affirmation of the district court's determination that Petitioner's interpretation of the ERISA Plan was arbitrary and capricious since the district court in granting summary judgment applied ERISA law to determine that Petitioner acted "arbitrarily and capricious." (Pet. App. C-9 – C-10.) Knudson should not be asked to

4. The facts of this case do not support the issue framed by Petitioner's writ of certiorari. Respondent Knudson's case was affirmed on the merits which applied ERISA law in interpreting the recovery language in the plan document. Therefore, any suggestion that other counsel be appointed to argue the jurisdictional issue invites an advisory opinion from this Court. In short, the foundational basis for the jurisdictional issue is not supported by this case.

switch sides and for the first time argue against the complaint's framing an ERISA cause of action. To do so would be enter into the territory of a collusive action, *i.e.*, a ruse to feign a controversy in order to obtain an advisory opinion.

Petitioners in their letter to the Court Clerk, dated February 13, 2001 failed to note that the Ninth Circuit addressed the merits on appeal and affirmed the judgment of the district court. The case of *Cardinal Chemical Co. v. Morton International Inc.*, 508 U.S. 83 (1993) is not dispositive of the issues presented. First, that case is a patent case where unique rules apply. Second, *Cardinal Chemical Co.* involved three cases with reoccurring issues over a patent.

The present case, *Great-West v. Knudson*, is distinguishable in that the *Knudson* district court applied ERISA law in interpreting the plan unlike the courts in *Cement Masons v. Stone*, 197 F.3d 1003 (9th Cir. 1999), *pet. for cert. pending*; *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 1999), *cert. denied*, __ U.S. __ (2001) and *FMC Med. Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997). Further, as noted above, Respondent Knudson prevailed on the merits.

Simply, the instant case does not provide a foundation to resolve the conflict between the circuits. It has no precedential value. Therefore, the suggestion of appointment of counsel to argue on behalf of the Ninth Circuit, or amicus counsel to argue in favor of the holding in *FMC v. Owens* is inappropriate. Simply, there is no case or controversy based upon the facts before this Court.

F. This Case Is Not One Where the Parties Failed to Brief or Argue a Dispositive Issue.

In *United States Nat'l Bank of Oregon v. Indep. Ins. Agents of America, Inc.*, 508 U.S. 439 (1993), the respondent did not address whether a statute was repealed or not, despite the court's invitation to do so at oral argument. *Id.* at 445-47. Even when the court ordered the respondent to file supplemental brief on the validity of the statute, the respondent did not take a position on the merits. *Id.* This Court in holding that the Court of Appeals was within its authority to consider the validity of the statute, stated that "a court may consider an issue 'antecedent to . . . and ultimately dispositive of' the dispute before it, even an issue the parties fail to identify and brief." *Id.* at 447, citing *Arcadia v. Ohio Power Co.*, 498 U.S. 73, 77 (1990). Nevertheless, the foregoing is not applicable since: (1) the parties briefed the issue, and (2) the lower court's judgment was affirmed on the merits.

There is a substantial difference between the situation when a party fails to set forth a meritorious argument, such as in the case in *United States Nat'l Bank of Oregon*, and the case where there is no meritable counter-argument. As Knudson explains in detail below, this Court has unequivocally held since *Pilot Life Ins.*, 481 U.S. 41, that ERISA preempts state law that relate to ERISA plans. In the instant case, there is no *bona fide* argument to the support the position that state contract law overrides ERISA when interpreting the reimbursement clauses.

In the present case, both Petitioner and Knudson are of the position that Petitioner's complaint framed an ERISA cause of action. Knudson further contends that the district

court correctly applied ERISA law in granting her summary judgment motion. Petitioner disagrees, but that issue is not before this Court.

Had Petitioner argued in the Ninth Circuit that its complaint had framed no issue under ERISA in an attempt to evade the district court's adverse ERISA ruling, then a controversy on this issue would exist. Since Petitioner argued *in favor of* an ERISA cause of action, no controversy between Petitioner and Knudson exists. Before the Court of Appeals for the Ninth Circuit, Knudson made her position clear by showing there was no "case or controversy" and by arguing the real ERISA issue on appeal, *i.e.*, whether the district court correctly held that Petitioner's interpretation of the plan was "arbitrary and capricious." (Knudson's Ninth Circuit Answering Brief, pgs. 9, 40.)

II.

THERE IS NO MERIT TO THE POSITION THAT AN ERISA PLAN MAY NOT APPLY ERISA LAW IN ORDER TO DETERMINE WHETHER A PARTICIPANT SHOULD REIMBURSE SOME OR ALL OF THE FUNDS.

A. ERISA Requires Uniformity of Law.

ERISA is a comprehensive scheme which requires uniformity in its interpretation. *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 52-53 (1987). Common law causes of action such as breach of contract are preempted by ERISA. *Id.* ERISA requires a civil enforcement scheme which is essential for accomplishing the stated purposes of ERISA. *Id.*

> In sum, the detailed provisions of 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54.

If an ERISA plan or its insurer filed in state court utilizing state contract law to adjudicate its rights under the reimbursement provisions of its ERISA plan, then "the federal scheme would be completely undermined." *Id.* at 52-54. On the other hand, the ERISA plan or the beneficiary can file in state court so long as ERISA law is applied in interpreting the language of the plan.[5]

In order to determine whether a participant owes reimbursement under an ERISA plan a court must *interpret the terms of the ERISA plan*. State laws cannot be used to interpret the provisions of an ERISA plan. *Pilot Life Ins.*, 481 U.S. at 52-53.

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5. It should be noted that nothing in *Pilot Life Ins. Co.*, 481 U.S. 41 *or Met. Life Ins. Co.*, 481 U.S. 58 addresses the issue of state courts' applying ERISA law. In fact, 29 U.S.C. § 1132 expressly provides for **concurrent state** court and federal court **forum** jurisdiction to apply ERISA. The proper forum issue is not involved in this case.

B. If ERISA Law Does Not Preempt, Then States Could Enact Statutes Governing Reimbursement Provisions of ERISA.

The Ninth Circuit's view opens the way for each state to enact its own scheme how to construe a plan's reimbursement provisions. It would be ludicrous to hold that when a plan participant wants to clarify his reimbursement obligation under 29 U.S.C. § 1132(a)(1)(B), he has to file under ERISA, but when the plan wants to adjudicate those same rights, it has to file under some state contractual law. This situation cannot exist as states are not allowed to pass legislation which relates to ERISA Plans. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987).

C. An Award Of Money Does Not Nullify ERISA.

The idea that a claim for reimbursement is somehow transformed into an at law action for damages merely because the lawsuit might result in the participant's owing money to the ERISA plan is devoid of legal merit. For example, a participant's lawsuit to determine his rights under a plan could result in a plan's having to pay money for a medical procedure. The possible outcome does not mean that the plan participant's lawsuit falls under state law and not under 29 U.S.C. § 1132(a)(1)(B).

D. If ERISA Does Not Apply, Plan Participant Rights Would Be Adjudicated Under ERISA While the Plan's Rights Under The Same Provisions Would Be Adjudicated Under State Contract Law.

The participant has a right to file under 29 U.S.C. § 1132(a)(1)(B) to determine rights under an ERISA plan, arguing that no reimbursement is owed.

The Ninth Circuit apparently agrees that ERISA would apply since the participant is not seeking money damages. Yet, if the plan were to file in order to enforce the plan's interpretation of that same ERISA plan, the case would *not* fall under ERISA. As pointed out above, such a position is not supportable under ERISA. In *American Airlines, Inc. v. Wolens*, 513 U.S. 219, 232 (1995) this Court states:

> In this regard, the ADA contrast markedly with ERISA, which does channel civil actions into federal courts, see ERISA §§ 502(a), (e), 29 U.S.C. §§ 1132(a), (e), . . . *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54, 95 L. Ed. 2d 39, 107 S. Ct. 1587 (1987); see, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143-145, 112 L. Ed. 2d 474, 111 S. Ct. 478 (1990) (finding ERISA's comprehensive civil enforcement scheme a "special feature" supporting preemption of common law wrongful discharge claims.)

American Airlines v. Wolens, 513 U.S. at 232.

Congress' intention was to funnel all civil actions which affected the operation of ERISA plans into ERISA's comprehensive scheme.

SUMMARY

No party in this case argued against ERISA being the applicable law. Since the only issue certified before this Court is not in controversy, this Court has no jurisdiction to hear the case. This Court has held that ERISA preempts state law that relate to ERISA plans. State law cannot be used to interpret ERISA plans' reimbursement clauses.

By belatedly raising the present issue on appeal, Petitioner is asking the federal courts to issue what amounts to an advisory opinion. As the Ninth Circuit Court opinion in *Great West v. Knudson* is not published, it has no precedent value. Thus, this case should terminate now by its dismissal.

CONCLUSION

Respondent Janette Knudson respectfully requests that this Court dismiss the appeal on the grounds that there is no case or controversy and that the writ of certiorari was improvidently granted.

Respectfully submitted,

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

Attorneys for Respondent
Janette Knudson

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Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Petition for a Writ of *Certiorari* to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND IN SUPPORT OF PETITION FOR WRIT OF *CERTIORARI*

WILLIAM J. NELLIS
Secretary to the Board of Trustees
Central States, Southeast and Southwest Areas Health and Welfare Fund
9377 W. Higgins Road
Rosemont, IL 60018
(847) 518-9800

JOHN A. KUKANKOS
Counsel of Record
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One N. Franklin Street
Suite 900
Chicago, IL 60606
(312) 357-9200

Attorneys for Amicus Curiae

Midwest Law Printing Company/Photex — Chicago — (312) 321-0220

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MOTION FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund"), pursuant to Supreme Court Rule 37, respectfully moves this Honorable Supreme Court of the United States of America to grant it leave to file a brief *amicus curiae* in support of the Petition for Writ of *Certiorari* filed by Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. (collectively, "Petitioners"). The Welfare Fund submits its brief *amicus curiae* together with this motion. In support, the Welfare Fund states:

1. Petitioners have consented to the filing of the Welfare Fund's brief *amicus curiae*. The Welfare Fund has been unable to obtain the consent of Respondents Janette Knudson and Eric Knudson to the filing of the Welfare Fund's brief *amicus curiae*. Petitioners' letter of consent accompanies this motion for filing with the Clerk of this Court.

2. The Welfare Fund is a Taft-Hartley trust and an employee benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985). Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country who negotiate collective bargaining agreements with their employers. The employers pay contributions to the Welfare Fund to fund benefits for Beneficiaries.

3. The Welfare Fund provides medical, hospital, dental, disability, vision and life benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and not-for-profit. Like Petitioners, the Welfare Fund has implemented a subrogation program which it actively enforces in all jurisdictions where its Beneficiaries reside.

4. The issue in this case is whether an employee benefit plan regulated by ERISA can sue in federal court to obtain reimbursement of paid medical benefits from the proceeds of its beneficiary's personal injury settlement. The resolution of this issue depends upon whether such an action seeks equitable relief under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3).

5. Pending before this Court are separate petitions for writs of *certiorari* in the following cases which involve the above issue: a) the case at bar; b) *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 2000), *petition for cert. filed*, No. 99-1787 (U.S. May 10, 2000) (the "*Ellis* Case"); and c) *Cement Masons Health and Welfare Trust Fund for Northern California v. Stone*, 197 F.3d 1003 (9th Cir. 1999), *petition for cert. filed*, No. 99-1403 (U.S. Feb. 22, 2000) (the "*Stone* Case"). Each of these cases involves a decision of the Ninth Circuit holding that the above relief is not equitable relief and that the federal court therefore lacks jurisdiction to hear such matter under ERISA.

6. On May 30, 2000, this Court allowed the motions of the Welfare Fund and other employee benefit plans to file briefs *amicus curiae* in support of the Petition for a Writ of *Certiorari* in the *Stone* Case. On that same date, this

Court invited the Solicitor General to file a brief in the *Stone* Case. The Welfare Fund is also filing its Motion for Leave to File a Brief *Amicus Curiae* in the *Ellis* Case together with the filing of this motion.

7. The Welfare Fund seeks leave to file its brief *amicus curiae* to bring to the attention of the Court relevant matters not raised by Petitioners, *viz.*, the effect which the Ninth Circuit's decision will have on large employee benefit plans, such as the Welfare Fund, which operate in many states. For these employee benefit plans, the decision of the Ninth Circuit will cause the exact harm which Congress sought to prevent in enacting ERISA. The decisions of the Ninth Circuit in this case, the *Ellis* Case, and the *Stone* Case impact large, multi-state employee benefit plans in the same way. For that reason, the Welfare Fund's briefs in each case are essentially the same.

8. In enacting ERISA, Congress recognized the importance of employee benefit plans, the problems which conflicting state and local regulation could cause for such plans, and the need for exclusive federal regulation of such plans to ensure uniformity in enforcement of plan terms. This Honorable Court has, on many occasions, noted these laudable goals of ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974)); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

9. The Ninth Circuit's decision not only creates a split in the Circuits, but also directs plans to state court as the exclusive forum for enforcing the terms of the plan and redressing violations of the terms of the plan. For these

reasons, that decision will create the exact patchwork enforcement of plan terms which Congress sought to avoid in enacting ERISA.

10. As discussed in the brief *amicus curiae*, because ERISA preempts state laws, 29 U.S.C. § 1144(a), and provides plan fiduciaries with access to federal district courts which have exclusive jurisdiction in actions to enforce plan terms and redress violations of plan terms, 29 U.S.C. §§ 1132(a)(3) and 1132(e), directing fiduciaries to state courts for such actions may result in no remedy at all. Moreover, that direction invites state courts to apply a wide range of varying state laws which diminish or eliminate subrogation rights in different ways from state to state.

11. Finally, subrogation results in significant cost-savings for the Welfare Fund. Since its inception in 1984, the Welfare Fund's subrogation program has achieved direct reimbursements and savings of approximately $62.0 million. Because the decision of the Ninth Circuit will result in the diminishment of subrogation recoveries and savings, that decision will lead to the inevitable reduction in benefits for Beneficiaries—a result which further detracts from ERISA's goals as described in *Shaw*, 463 U.S. at 99, and *FMC*, 498 U.S. at 60.

For each of the above reasons, the Central States, Southeast and Southwest Areas Health and Welfare Fund requests this Honorable Court to grant it leave to file the Welfare Fund's brief *amicus curiae*.

Respectfully submitted,

JOHN A. KUKANKOS
One of the Attorneys for
Central States, Southeast
and Southwest Areas Health
and Welfare Fund

JOHN A. KUKANKOS
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One North Franklin Street
Suite 900
Chicago, Illinois 60606
(312) 357-9200

WILLIAM J. NELLIS
Secretary to the Board of Trustees
Central States, Southeast
and Southwest Areas Health
and Welfare Fund
9377 West Higgins Road
Rosemont, Illinois 60018
(847) 518-9800

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BRIEF OF *AMICUS CURIAE*

I. THE INTEREST OF THE *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund") is an employee benefit plan as defined in Section 3(1) of the Employee Retirement and Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985).[1] Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country who negotiate collective bargaining agreements with their employers. These collective bargaining agreements require employers to pay a certain level of contributions to the Welfare Fund in return for a set benefit package offered by the Welfare Fund for that particular contribution rate. Each contributing employer executes a participation agreement with the Welfare Fund agreeing, among other things, to pay the required contributions and to abide by all rules and regulations set by the Welfare Fund Trustees who administer the Welfare Fund. Established under the Taft-Hartley Act, the Welfare Fund has ten trustees—five appointed by contributing employers and five elected by the unions whose members are Beneficiaries. *See* 29 U.S.C. § 186.

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[1] As provided in United States Supreme Court Rule 37.6, the Welfare Fund states that no counsel for any party authored any part of this brief, and that no person other than *amicus curiae*, its members, or its counsel made any monetary contribution to the preparation or submission of the brief.

The Welfare Fund provides medical, hospital, dental, vision, life and disability benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and pays benefits directly from the contributions of participating employers. The Welfare Fund is not-for-profit, and its assets are used exclusively to provide benefits for Beneficiaries or to defray the reasonable costs of administering the benefit plan. *See* 29 U.S.C. § 1104(a)(1)(A).

ERISA and the law of trusts require plan fiduciaries to manage the assets of the Welfare Fund prudently and in the best interests of all beneficiaries. 29 U.S.C. § 1104(a)(1)(B). To comply with these requirements, the Welfare Fund has implemented cost-containment measures including the promulgation of a subrogation provision. This provision requires Beneficiaries who receive recoveries in accident cases to, among other things, reimburse the plan from any recovery in the full amount of accident-related benefits advanced by the Welfare Fund. Since its inception in 1984, the Welfare Fund's subrogation program has achieved recoveries and savings totaling approximately $62.0 million.

Since benefit levels are based on actuarial assumptions which assume a certain level of subrogation recoveries, such recoveries are necessary to provide assets sufficient to fund the benefit levels stated in the various benefit plans offered by the Welfare Fund. Like other large multiemployer plans where contribution rates are set pursuant to collective bargaining agreements and a participation agreement, the Welfare Fund cannot unilaterally increase contribution rates. Thus, if subrogation recoveries are reduced, benefits provided to Beneficiaries will be correspondingly reduced.

The Welfare Fund will be materially and adversely affected by the decision of the Ninth Circuit Court of Appeals in this case. That decision conflicts with decisions of the Seventh, Eighth and Eleventh Circuits which permit the enforcement of subrogation and reimbursement rights in federal courts. *See Administrative Comm. v. Gauf*, 188 F.3d 767 (7th Cir. 1999); *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *Southern Council of Indus. Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996). If the Ninth Circuit's decision is allowed to stand, state courts will be the exclusive forum for enforcement of the Welfare Fund's subrogation rights in that Circuit. As a result, and as discussed herein, the Welfare Fund will be able to enforce in piecemeal fashion only, or not at all, its subrogation rights in the Ninth Circuit and other jurisdictions which follow the Ninth Circuit's lead. In contrast, the Welfare Fund will be able to fully enforce its subrogation rights in the Seventh, Eighth and Eleventh Circuits and other jurisdictions. Contrary to the intent of Congress when it passed ERISA, the above split in the Circuits will lead to non-uniform enforcement of the Plan and impose a costly administrative burden on the Plan because the Welfare Fund enforces its subrogation rights in many jurisdictions. In addition, allowing the Ninth Circuit's decision to stand will lead to a reduction of subrogation recoveries and the consequent loss of benefits for Plan Beneficiaries.

Moreover, the decision of the Ninth Circuit will have implications for many other employee benefit plans.

Many multiemployer plans and plans of single employers with nationwide facilities operate in many different states. The Ninth Circuit's decision will cause for these plans the same reduction in subrogation recoveries, increase in administration expenses, and patchwork enforcement of plan terms. The administrative difficulty and added expense caused by such a piecemeal scheme of federal and state regulation of multistate employee benefit plans which Congress rejected when it passed ERISA will thus become a reality for many ERISA plans. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9-11 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-08 (1983).

II. SUMMARY OF THE ARGUMENT

The Welfare Fund seeks to bring to the Court's attention matters not focused on by Petitioners. When it passed ERISA into law, Congress recognized the national interest in employee benefit plans, and the need for exclusive federal regulation of such plans to ensure uniformity in enforcement of plan terms and to eliminate conflicting state and local regulation of such plans. For large multistate plans like the Welfare Fund, the Ninth Circuit's decision makes these laudable goals of ERISA unattainable, creates added administrative expense, and results in reduced subrogation recoveries and consequent reduced benefits for Beneficiaries.

For several reasons, the decision of the Ninth Circuit causes the very harm which ERISA was designed to prevent. First, the Ninth Circuit's decision conflicts with decisions of the Seventh, Eighth and Eleventh Circuits,

causing the unequal, non-uniform enforcement of the Welfare Fund's subrogation provision. Second, the requirement that multistate plans sue in state court to enforce subrogation rights invites state courts to apply a panoply of state laws which diminish or eliminate subrogation rights, further fostering piecemeal enforcement of plan terms.

Moreover, the decision of the Ninth Circuit prevents plan fiduciaries from enforcing the terms of the plan and redressing violations of plan terms as required by ERISA. *See* 29 U.S.C. § 1132(a)(3). In fulfilling these obligations, Congress authorized plan fiduciaries to sue exclusively in federal court to obtain equitable relief under ERISA. 29 U.S.C. §§ 1132(a)(3), 1132(e). In denying the Trustees relief in federal court, the forum which has exclusive jurisdiction over these matters, the Ninth Circuit's decision effectively bars plan fiduciaries from enforcing plan terms as required by ERISA.

III. ARGUMENT: REASONS FOR GRANTING THE WRIT

A. The Decision of the Court of Appeals for the Ninth Circuit Prevents Uniform Administration of Multistate Employee Benefit Plans and Thus Frustrates the Primary Purpose of ERISA.

1. In Promulgating ERISA, Congress Recognized the Importance of Employee Benefit Plans and the Need for Exclusive Federal Regulation of Such Plans to Ensure Uniformity in Enforcement of the Terms of the Plan.

When Congress enacted ERISA in 1974, it recognized that employee benefit plans involved the national public

interest and stressed the importance of the uniform federal regulation of such plans. Congress set forth its findings and declaration of policy in Section 2 of ERISA, which, in part, provides:

> The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations.

29 U.S.C. § 1001(a). As recognized by this Court, ERISA's legislative sponsors emphasized the necessity for uniform federal regulation of not only the substantive provisions, but also of enforcement provisions applicable to such plans:

> "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law."

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974));[2] *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

In order to permit plan Trustees to structure plan provisions uniformly for all plan participants, Congress enacted ERISA's preemption provisions. *See* 29 U.S.C. § 1144. To further this same purpose, Congress enacted Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), ERISA's enforcement provision, allowing plans to sue to obtain equitable relief to enforce plan terms and redress violations of plan terms. To ensure uniform enforcement of plan terms, Congress provided that federal district courts shall have exclusive jurisdiction in the above actions. *See* 29 U.S.C. § 1132(e).

Congress rejected amendments to ERISA which would have required ERISA plans to comply with multiple and potentially conflicting state laws which would raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. *Shaw*, 463 U.S. at 99 n.20. Thus, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, stating that "'the

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[2] Senator Javits echoed these comments, stating: "'Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.'" *Shaw*, 463 U.S. at 99 n.20 (quoting 120 Cong. Rec. 29942 (1974)).

Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Id.* (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess., at 47 (1977)).

This Court has also on several occasions noted the necessity for exclusive federal regulation of employee benefit plans. In *Shaw*, the Court considered the question of whether New York's Disability Benefits Law was preempted by ERISA. In finding preemption, this Court noted that the obligation of the plans to comply with "the varied and perhaps conflicting" requirements of particular state fair employment laws would make nationwide administration of plans more difficult. 463 U.S. at 105 n.25. The Court emphasized that this sort of interference with the administration of employee benefit plans was exactly what ERISA's comprehensive preemption of state law was designed to minimize. *Id.*

In *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), this Court recognized that requiring an employer to adopt different payment formulae for employees inside and outside the State would subject the employer to precisely the burden that ERISA preemption was intended to eliminate. *Id.* at 10.[3] This court recognized the difficulties which these state rules imposed on plan administrators and stated:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Id. at 9.

ERISA's uniform enforcement mechanism complements ERISA's administrative scheme. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court again confirmed that ERISA was designed to achieve uniformity of deci-

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[3] Since the laws and regulations applicable to health care benefits vary widely from state to state, the disruptive effect of state regulation is compounded for employee benefit plans, such as the Welfare Fund, which have employees in more than one state. Benefit plans which operate in many states often choose to self-fund benefit payments rather than purchase insurance to cover such benefits. Because state laws vary dramatically, purchasing insurance for plans which operate in (continued...)

[3] (...continued)
many states is inefficient, inequitable and increasingly expensive. It was for this reason that Congress passed the preemption clause of ERISA, 29 U.S.C. § 1144. *See Fort Halifax*, 482 U.S. at 10; *see also FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

sion to assist fiduciaries "'to predict the legality of proposed actions without the necessity of reference to varying state laws.'" *Id.* at 56 (quoting H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650). This Court noted ERISA's expectation that federal courts would develop federal common law:

> The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws.

Pilot Life, 481 U.S. at 56.

This Court also noted in enacting ERISA, Congress realized that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities:

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. 1, 11 (1987) (citing H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650).

2. The Decision of the Ninth Circuit Fosters the Very Harm Which Congress Sought to Prevent in Enacting ERISA.

The Ninth Circuit's decision will create the exact patchwork scheme of regulation and enforcement which Congress sought to avoid in enacting ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Most obviously, the split in the Circuits which the Ninth Circuit's decision creates will result in the unequal, non-uniform enforcement of the Welfare Fund's subrogation provision. First, denying ERISA plans the right to enforce subrogation rights in federal court under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), may indeed result in the complete abrogation of such rights. Courts in a number of jurisdictions have held that federal courts have exclusive jurisdiction in enforcing such rights and have dismissed lawsuits seeking to enforce these rights. *See*, e.g., *Descant v. Administrators of the Tulane Educ. Fund*, 706 So. 2d 618 (La. Ct. App. 1998); *Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr.2d 723 (Cal. Ct. App. 1996). In fact, ERISA itself provides that federal district courts shall have exclusive jurisdiction over enforcement of plan terms. 29 U.S.C. § 1132(e).

Second, the requirement that multistate plans sue in state court to enforce their subrogation provisions invites state courts to apply local laws which diminish subrogation rights and prevents the uniform enforcement of plan terms. *See Ingersoll-Rand*, 498 U.S. at 142. For example, the laws of some states prohibit the enforcement of subrogation rights against uninsured motorist recoveries, recoveries by minors, or recoveries which do not

make a plan participant whole. In other states, the amount of the recovery may be reduced by an award of *pro rata* attorney's fees for a participant's attorney under the common fund doctrine.[4]

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[4] Federal courts are often forced to decide whether to apply state laws that would forbid or limit an ERISA plan's subrogation rights. When confronted with this issue, most federal courts have held that ERISA preempts such laws or that the written language of the plan overrides such laws. *See, e.g.*, *FMC*, 498 U.S. 52 (1990) (ERISA preempts state automobile insurance anti-subrogation law); *Community Ins. Co. v. Richardson*, 172 F.3d 872 (6th Cir. 1999) (ERISA preempts Ohio statute prohibiting reimbursement of medical claims from municipalities); *Electro-Mechanical Corp. v. Ogan*, 9 F.3d 445 (6th Cir. 1993) (ERISA preempts Tennessee statute prohibiting subrogation of health care costs in malpractice cases); *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992) (ERISA preempts North Carolina subrogation statute limiting a self-funded ERISA plan's recovery from third party settlement funds); *Davis v. Line Constr. Benefit Fund*, 589 F. Supp. 146 (W.D. Mo. 1984) (ERISA preempts State law preventing subrogation of an otherwise unassignable personal claim).

Courts have also considered application of the common fund doctrine to ERISA plans. *See, e.g., Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 940 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998); *Bollman Hat Co. v. Root*, 112 F.3d 113, 118 (3rd Cir. 1997), *cert. denied*, 522 U.S. 952 (1997); *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997); *Ryan v. Federal Express Corp.*, 78 F.3d 123 (3rd Cir. 1996). In *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997), the court ruled that whether ERISA preempts the common fund doctrine depends on the language of the benefit plan. In *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1296 (7th Cir. 1993), *cert. denied*, 510 U.S. 916 (1993), and (continued...)

The decision of the Ninth Circuit will create huge burdens on multistate plans and force such plans to rely on myriad rules to enforce subrogation and reimbursement rights. Uniformity in the application of plan terms will cease. The end result of the Ninth Circuit's decision will be the exact patchwork administration of employee benefit plans that Congress sought to avoid in enacting ERISA. *See FMC Corp.*, 463 U.S. at 60; *Fort Halifax*, 482 U.S. at 10-11; *Shaw*, 463 U.S. at 105, n.25.

B. If Allowed to Stand, the Ninth Circuit's Decision Will Diminish a Valuable Cost-Saving Mechanism for Self-Funded Plans.

Many of the cost-containment measures implemented by employee benefit plans transfer actual costs to beneficiaries or restrict the type, length or choice of medical care. Unlike such cost-containment measures, a subrogation provision merely prevents the duplication of benefits by the plan where other coverage exists for a particular injury or illness. In other words, the participant does not recover twice for accident-related medical damages, and the responsibility for the medical care is shifted to the party causing the injury or to the specific-risk insurer who has specifically assumed the kind of risk leading to the injury. Subrogation not only shifts the

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[4] (...continued)
Fields v. Farmers Ins. Co. Inc., 18 F.3d 831, 835-36 (10th Cir. 1994), courts held that the terms of the plan override contrary State laws related to subrogation in Wisconsin and Oklahoma, respectively. *See also* footnote 6, *infra*, pp. 15-16.

costs of medical care to the responsible party, but also constitutes a valuable cost-savings device. Since the inception of the Welfare Fund's subrogation program, the Welfare Fund has achieved recoveries and subrogation savings totaling approximately $62.0 million.

Under the Ninth Circuit's ruling, employee benefit plans will be ushered to state court to enforce their subrogation rights. As discussed previously, some state courts have held that the federal courts have exclusive jurisdiction over such matters and will, therefore, not entertain such actions. Other states may indeed apply laws which prohibit or diminish the enforcement of subrogation rights. (*See* footnote 4, *supra*, pp. 12-13.) The inevitable result of the Ninth Circuit's ruling will be a loss in subrogation recoveries for the Welfare Fund and other plans, and the consequent loss of benefits for plan participants.[5]

[5] The Ninth Circuit's decision could lead benefit plans to reconsider their policy of advancing payment for medical bills related to injuries sustained in accidents. If benefit plans cannot enforce their subrogation rights in certain states, and in order to avoid having one employer subsidize the benefits of another employer's employees, plans could add plan provisions to exclude from coverage claims related to accidents in those states where the plan's subrogation provision could not be enforced. Although compensating for lost subrogation recoveries, this added layer of administration would delay payment of a beneficiary's benefits, increase the costs of administering the plan, and lead to the hodge-podge administration of plans which ERISA condemned.

C. The Decision of the Ninth Circuit Prevents the Trustees From Administering the Plan in Accordance with ERISA's Mandate.

ERISA requires that every employee benefit plan be established pursuant to a written instrument and that named fiduciaries control and manage the operation and administration of the Plan. 29 U.S.C. § 1102(a)(1). Congress bestowed upon fiduciaries the power and authority to accomplish these objectives by enacting ERISA's enforcement mechanism. Section 502(e) of ERISA, 29 U.S.C. § 1132(e), affords fiduciaries access to federal courts to enforce plan terms and to redress violations of plan terms. The Ninth Circuit's decision, which denies access to federal court, prevents fiduciaries from administering the Plan as required by ERISA.

Subrogation is not a simple contractual matter between an insured and its insurer where state issues predominate. Subrogation involves enforcing the written terms of the plan under the enforcement mechanism of ERISA. In many instances, the enforcement of subrogation rights by a self-funded employee benefit plan involves the interpretation of a plan's precise subrogation provision—a function best left to the discretion of plan Trustees.[6] Because

[6] For example, plan fiduciaries must decide whether the written terms of the plan include recoveries from tortfeasors as well as their insurers or recoveries from uninsured motorist coverage. *See Health Cost Controls v. Washington*, 187 F.3d 703, 711-12 (7th Cir. 1999), *cert. denied*, 120 S. Ct. 979 (2000); *Wendy's Int'l, Inc. v. Karsko*, 94 F.3d 1010, 1013 (6th Cir. 1996); *Sunbeam-Oster Co., Inc. v. Whitehurst*, 102 F.3d 1368, 1378 (5th Cir. 1996). Another question of interpretation arises when the

(continued...)

ERISA considerations permeate the enforcement of Plan terms such as subrogation, Congress legislated that federal district courts have exclusive jurisdiction to enforce Plan terms and redress violations of those terms. These are core ERISA issues best left, as Congress intended, to the federal courts. Contrary to the Ninth Circuit's position, the equitable relief which Congress set forth in ERISA is sufficient to accomplish these objectives.

IV. CONCLUSION

The Ninth Circuit's decision is directly at odds with the goals of Congress in enacting ERISA. If the decision of the Ninth Circuit is permitted to stand, employee benefit plans will be subjected to non-uniform regulations and enforcement. The consequent increased administrative expenses and decreased subrogation recoveries will result in a loss of benefits for plan beneficiaries. Plan fiduciaries will be denied the uniform enforcement mechanism needed to enforce plan terms and redress violations of plan terms. For the reasons stated above, Central States, Southeast and Southwest Areas Health and Welfare

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[6] (...continued)
written terms of the plan set the priority of allocations between the subrogee and subrogor. *See Cagle v. Bruner*, 112 F.3d 1510, 1520-22 (11th Cir. 1997), *reh'g denied*, 124 F.3d 223 (11th Cir. 1997); *Sunbeam-Oster Co.*, 102 F.3d at 1373-76; *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293 (7th Cir. 1993), *cert. denied*, 510 U.S. 916 (1993). *See also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (arbitrary and capricious standard applied when plan gives fiduciary discretionary authority to construe terms of plan).

Fund respectively requests this Honorable Court to grant the Petition for Writ of *Certiorari*.

June 8, 2000.

Respectfully submitted,

WILLIAM J. NELLIS
Secretary to the Board
of Trustees
Central States, Southeast
and Southwest Areas
Health and Welfare Fund
9377 W. Higgins Road
Rosemont, Illinois 60018
(847) 518-9800

JOHN A. KUKANKOS
Counsel of Record
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One N. Franklin Street
Suite 900
Chicago, Illinois 60606
(312) 357-9200

Attorneys for Amicus Curiae

(3)

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GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.

Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF PETITIONERS

J. Dudley Hyde
Richard D. Nix
Mark D. Spencer*
**Counsel of Record*
McAFEE & TAFT
A Professional Corporation
10th Floor, Two Leadership Square
211 North Robinson Avenue
Oklahoma City OK 73102
(405) 235-9621

17 pp

MOTION FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF

The Self-Insurance Institute of America, Incorporated (SIIA) moves for leave to file an *amicus curiae* brief pursuant to Supreme Court Rule 37.2(b). This brief is filed with the consent of Petitioners, and a letter reflecting this consent has been filed with the Clerk of the Court. Respondents, Janette Knudson and Eric Knudson, have withheld their consent to the filing of this brief.

The issue in this case complements the issue in *Cement Masons Health & Welfare Trust Fund for Northern Cal.v. Stone,* 197 F.3d 1003 (9th Cir. 1999), *petition for cert. filed,* 68 U.S.L.W. 3566 (U.S. Feb 22, 2000)(No. 99-1403).

Last week, on May 30, 2000, the Court invited the Solicitor General to file an *amicus curiae* brief in *Stone*, and granted motions for leave to file *amicus curiae* briefs by: Health Insurance Association of America; International Training Institute for Sheet Metal and Air Conditioning Industry; Multiemployer Trust Funds; and Central States, Southeast and Southwest Areas Health and Welfare Fund.

There is currently a split among the circuits as to whether an employee benefit plan fiduciary may seek to recoup benefits paid in third-party liability situations under ERISA Section 502(a)(3) when the remedy involves a monetary recovery.

For this reason, SIIA respectfully requests that its Motion For Leave To File *Amicus Curiae* Brief be granted.

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INTEREST OF *AMICUS CURIAE*

The Self-Insurance Institute of America, Inc. (SIIA) submits this brief in support of Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Plan for Employees and Dependants of Earth Systems, Inc.'s Petition for a Writ of Certiorari.[1]

SIIA is a non-profit corporation having over 700 members, representing almost fifteen million Americans, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes users of self-insurance such as employer plan sponsors, as well as service providers such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. §§ 1001 *et seq.*, concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members.

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[1] Counsel of record for SIIA, Mark Spencer, certifies pursuant to Supreme Court Rule 37.6 that this brief was not authored in whole or in part by counsel for a party and that no person or entity, other than the *amicus curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

SIIA has an interest in the ERISA pre-emption issue presented in this case -- whether an employee benefit plan fiduciary may seek to recoup benefits paid in third-party liability situations under ERISA Section 502(a)(3) (29 U.S.C. § 1132(a)(3)) when the remedy involves a monetary recovery.

First, the issue presented is of major concern to the self-insurance industry because the rising cost to employers of providing health benefits will escalate if self-insurance plans are not able to recoup their losses in third-party tortfeasor situations using the tools Congress supplied under ERISA. This will result either in reduced health care benefits, or higher out-of-pocket costs for participants in the form of higher co-payments and deductibles, or both. The Ninth Circuit's decision may even threaten the continued viability of self-insurance as a cost-effective alternative for providing health benefits to millions of employees.

Second, because many SIIA employer members operate on a multi-state basis, they are legitimately concerned that any erosion of ERISA's pre-emption provisions will lead to plans abandoning attempts to recover money paid to participants. These participants agreed to reimburse the plan if they received money from a third-party tortfeasor, but later may decide to keep the double recovery and hide behind the state court system at the expense of other plan participants. This is exactly what Congress intended to avoid by enacting ERISA.

ARGUMENT

The Issue in this Case, Involving Abdication of Exclusive Federal Jurisdiction Within a Completely Pre-empted Field, Affects the Interests of Millions of Participants in Self-Insured and Fully-Insured Benefit Plans.

When it enacted ERISA, Congress found that the growth in numbers and size of employee benefit plans had been substantial, and that "the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest. . . ." 29 U.S.C.§ 1001(a). The stated policy of ERISA is "the interests of participants in employee benefits plans . . . by providing for *appropriate remedies*, sanctions, and *ready* access to the Federal courts."[2] 29 U.S.C. § 1001(b)(emphasis added).

Congress capped off the federal legislation with a pre-emption provision that has been described as "sweeping." *See* 29 U.S.C. § 1144(a).[3] ERISA pre-emption is so powerful that it displaces not only state legislation, but *any* form of state action including state lawsuits that "relate to" benefit plans. *See* 29 U.S.C. § 1144(c)(1)(broadly defining "state action"). Pre-emption of state law is even more forceful with respect to "self-insured" plans (as opposed to "fully-insured" plans). *See* 29 U.S.C. § 1144(b)(2).[4]

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[2] 29 U.S.C. § 1001(b).

[3] *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985)(ERISA pre-emption provision is "sweeping").

[4] Under ERISA's "savings clause," state laws that regulate the "business of insurance" are saved from pre-emption. *See* 29 U.S.C. § 1144(b)(2)(A). However under ERISA's

ERISA also includes a civil enforcement section that establishes exclusive federal civil causes of action. *See* 29 U.S.C. § 1132(a). When read in connection with ERISA's pre-emption provisions, this civil enforcement section is so powerful as to displace any state cause of action within the pre-empted field. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987). Such actions are "necessarily federal in character" and may be removed from state court even if the federal question does not appear on the face of the plaintiff's well-pleaded state court complaint. *See id.* at 63-64. A corollary to this rule is that ERISA jurisdiction cannot be avoided through "artful pleading."[5]

Congress also included various "tools" to protect the federal nature of these federal civil actions. This includes for example, nationwide service of process under 29 U.S.C. § 1132(e)(1), which permits service wherever the defendant resides or may be found, thus avoiding Fourteenth Amendment minimum contacts hurdles to service of process. *See, e.g., Peay v. BellSouth Med. Assistance Plan*, 205 F.3d 1206, 1210 (10th Cir. 2000).

"deemer clause," benefit plans cannot be "deemed" to be in the business of insurance. *See* 29 U.S.C. § 1144(b)(2)(B). The result is that certain state laws which regulate the business of insurance are not preempted with respect to fully insured plans, but remain preempted with respect to self-funded plans. *See generally Mertens v. Hewitt Assoc's*, 508 U.S. 248 (1993), for a discussion of this distinction. As noted above, the Self-Insurance Institute of America has a significant interest in the regulation of self-insured benefit plans.

[5] *See generally Caterpillar, Inc. v. Williams*, 482 U.S. 386, 397 (1987)(where Congress intended complete pre-emption of state law, the "artful pleading" doctrine cannot be invoked).

Similar to nationwide service in federal interpleader situations, *see* 28 U.S.C. § 1367, this permits parties to "lock" all interested or potentially interested parties to dispute into a single lawsuit regardless of where they happen to reside. This is very important for example, when there are numerous participants, beneficiaries, fiduciaries, and other parties interested in the dispute. Plans have sue-or-be-sued status so that they can be "heard" in federal court. *See* 29 U.S.C. § 1132(d)(1). Conflicting state laws are pre-empted. See 29 U.S.C. § 1144(a).

Finally, ERISA's civil actions are equitable in nature, meaning that courts can fashion a wide variety of remedies tailored to fit a particular situation. *See, e.g., Pane v. RCA Corp.*, 868 F.2d 631, 636 (3rd Cir. 1989). This is especially true in cases such as the one at bar arising under 29 U.S.C. § 1132(a)(3). *See Mertens v. Hewitt Assoc's*, 508 U.S. 248, 253-54 (1993). It also means that court-imposed remedies are enforceable through contempt, rather than through expensive and cumbersome state remedies such as "execution." *See, e.g., Pane*, 868 F.2d at 636.

One of ERISA's civil actions – the one at issue here is 29 U.S.C. § 1132(a)(3) – permits a plan fiduciary to bring an action for injunctive and equitable relief to enforce the provisions of ERISA and/or the terms of the plan, or to redress violations thereof. *See generally Mertens*, 508 U.S. at 253-54. This is a broad and open-ended statute that can encompass an almost infinite variety of situations where a person or entity has violated or is attempting to evade ERISA and/or the terms of the plan. *See id.* One of those situations is the one at bar, where a plan participant is violating a plan's terms requiring subrogation and reimbursement. *See id.* at 253.

Typically, these disputes arise in the context of a catastrophic injury to a plan participant by a third party. *See generally FMC Corp. v. Holliday*, 498 U.S. 52 (1990). The plan pays a significant sum to satisfy the participant's

medical bills. The participant then sues the tortfeasor and recovers a significant sum, but refuses to reimburse the plan. This results in a significant loss of plan assets (which must be borne by the plan participants or sponsor) and a double recovery to the injured participant (who has his/her bills paid in full and also recovers damages in the tort action).

To protect against this, many plans include provisions that give the plan a lien on any recovery by the participant, and require the participant to reimburse the plan from any recovery. These are "terms of the plan" within the meaning of 29 U.S.C. § 1132(a)(3). But frequently, participants and their attorneys, who are often in highly sympathetic positions, try to artfully craft ways to avoid the plan's subrogation/reimbursement provisions. This includes, for example, structured settlements, payments to persons other than the participant, agreed "findings" in the tort action that are "binding" on the participant, state declaratory actions, etc. Within this pre-empted field, however, these are merely "artful" efforts to violate the subrogation and reimbursement terms of the plan.

Congress provided a federal remedy under Section 1132(a)(3), which permits a plan fiduciary to file a federal cause of action to enforce the relevant terms of the plan, and to redress violations thereof. This is part of the "*ready* access" to federal courts envisioned by Congress. *See* 29 U.S.C. § 1001(b).

The attendant tools that accompany such federal actions -- nationwide service of process, sue-or-be-sued status, enforcement through contempt, etc. -- all operate to allow the plan to recover its losses, recoup its assets, maintain its financial integrity, and be restored to its former position. It also protects participants and beneficiaries

collectively in that restoration of funds ensures assets to pay future claims.[6]

Typically, the injured participant and the participants' attorneys, however, seek to evade their reimbursement obligations under plain terms of the plan. They characterize the plan's claim as one arising under state law, and argue that the plan must negotiate a maze of traditional state law hurdles such as restricted service of process, minimum contacts, discovery, jury trials, execution procedures, etc. to recover the lost assets.

But ERISA pre-empts these "state laws," which are defined as such under 29 U.S.C. § 1144(c)(1). This Court recently reaffirmed that the legislative purpose behind Section 1144(a) is "to ensure that plans and plan sponsors would be subject to a *uniform body of benefits law*; the goal was to *minimize the administrative and financial burden of complying with conflicting directives among States* or between States and the Federal Government..., [and to prevent] *the potential for conflict in substantive law...requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.*" *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 US 645, 656-57 (1995) (emphasis added).

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[6] In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 141-42 & n. 9 (1985), this Court held that ERISA's fiduciary regulatory scheme was designed to protect the participants and beneficiaries collectively, rather than to protect individual participants. Similarly, in ERISA restitution actions by plan fiduciaries under 29 U.S.C. § 1132(a)(3), federal courts should be primarily concerned about the welfare of the participants and beneficiaries collectively, rather than the welfare of a specific participant.

A lawsuit by a fiduciary to enforce the terms of a plan – whether those terms require subrogation, reimbursement, or other action – or a lawsuit to redress violations of such terms, falls squarely within the scope of Section 1132(a)(3). These lawsuits should be subject to a uniform body of federal law, and benefit plans should not be required to enforce their subrogation and reimbursement provisions based on the nuances and peculiarities of the state where the offending participant happens to be located.

Participants cannot avoid ERISA through "artful pleading," and federal courts should not be permitted to avoid ERISA through "artful" reasoning. In fact, federal district courts have *exclusive* jurisdiction over such actions. *See* 29 U.S.C. § 1132(e)(1). Federal courts have an unflagging obligation to exercise their exclusive jurisdiction over such actions. *See, e.g., Deakins v. Monaghan*, 484 U.S. 193, 203 (1988); *Thermtron v. Hermansdorfer*, 423 U.S. 336 (1976).

Unfortunately, there is a willingness by some federal courts to shirk this responsibility through what can only be called "artful opinion drafting" – the judicial equivalent of "artful pleading." Some federal courts, including the lower courts in this case, employ *Thermtron*-like logic[7] to divest themselves of cases that fall squarely within their jurisdiction. While this has the effect of lightening the federal caseload[8] and helping individual

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[7] *See Thermtron v. Hermansdorfer*, 423 U.S. 336 (1976). In *Thermtron*, this Court held that federal district courts cannot remand cases simply because they are "too busy" or do not want to adjudicate them.

[8] *Thermtron*-like disposal by federal courts of actions that fall within 29 U.S.C. § 1132(a)(3) is becoming especially prevalent in the context of removed actions, perhaps due largely to the fact that such orders are essentially non-reviewable. *See generally* Thomas R. Hrdlick, *Appellate*

participants in sympathetic circumstances retain large sums, it has a devastating financial effect on benefit plans, especially self-insured ones, and their participants and beneficiaries *collectively*.

The Ninth Circuit is rife with examples of such cases. *See, e.g., Barnes v. Independent Auto. Dealers.*[9] In *Barnes*, the Ninth Circuit adopted the make-whole rule. This rule mandated that plans pay for the medical expenses of injured participants and only then may the plans seek subrogation. The Ninth Circuit even held that the make-whole rule would not permit double recovery and that it was consistent with ERISA's related purpose of maintaining the interest of other employees in their benefit plans.[10] That was the Ninth Circuit's first barrier to plan recovery actions.

Here, the Ninth Circuit placed another hurdle in the path at such actions by holding that ERISA jurisdiction does not exist because the plan is seeking "money" rather than equitable relief. However, the Ninth Circuit previously held that Congress intended to provide courts with a "broad authority to fashion remedies." *See Donovan v. Mazzola*, 716 F.2d 1226, 1235 (9th Cir. 1983). Furthermore, the Ninth Circuit held in *Donovan* that "an order to pay money under ERISA is enforceable through contempt." *See id.* at 1240. Now, according to the Ninth Circuit, whenever a plan attempts to recover assets by filing a lawsuit to enforce its subrogation or reimbursement provisions, the action is not governed by ERISA Section 29 U.S.C. § 1132(a)(3), but is instead purely a matter of state concern.

Review of Remand Orders in Removed Cases: Are They Losing a Certain Appeal?, 82 Marq. L. Rev. 535 (1999).

[9] 64 F.3d 1389 (9th Cir. 1995).

[10] *Id.* at 1395.

This misses the point completely. Under ERISA, benefit plans must have ready access to the federal courts – and to the attendant tools that accompany federal actions under ERISA – to *enforce the terms of the plan* that require the participant to reimburse the plan for expenditures made on behalf of the participant, and to *redress violations* of such terms. This is in the nature of an "equitable" action for *specific performance* of the terms of the plan, *disgorgement* of wrongfully withheld funds, *restitution* of plan assets, etc. The mere fact that an equitable order requires the payment of money does not necessarily convert the case into a "legal" action.

Proof lies in this Court's decision in *Taylor*. *Taylor* held that an action by a plan participant seeking payment of "money" or "money damages" (*i.e.*, plan benefits) under a plan through a state law theory does not render the action exempt from ERISA. *See Taylor*, 481 U.S. at 62-63. Conversely, an action by a plan or a plan fiduciary seeking "money" (i.e., wrongfully withheld funds) from a plan participant is not exempt from ERISA. This conclusion is reinforced by ERISA's jurisdictional statute, which gives state courts *concurrent* jurisdiction over the former cases, but gives federal courts *exclusive* jurisdiction over the latter cases. *See* 29 U.S.C. § 1132(e)(1).[11]

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[11] Actions by plan fiduciaries for the recovery of plan assets fall under 29 U.S.C. § 1132(a)(3), and thus within the *exclusive* jurisdiction of the federal courts, whereas actions by participants for the recovery of benefits fall under 29 U.S.C. § 1132(a)(1)(B), *see Taylor*, 481 U.S. at 62-63, and thus within the *concurrent* jurisdiction of both state and federal courts. *See* 29 U.S.C. § 1132(e)(1). Consequently, federal courts should guard their jurisdiction *even more closely* in cases such as this one than in benefit disputes that are federalized under *Taylor*.

CONCLUSION

When federal courts abdicate their exclusive jurisdiction in these cases, as occurred here, participants are able to avoid ERISA and thus require plans to pursue recovery under varying and often inconsistent state laws. This includes expensive and time consuming discovery, trials, counterclaims, and other roadblocks. This is exactly what Congress intended to avoid by providing 29 U.S.C. § 1132(a)(3) and "ready access to federal courts" which provides more vigorous protection of employee benefit plans. The Ninth Circuit's decision in the present case provides participants and their lawyers that seek double recovery an opportunity to abuse the system at the expense of other participants.

Respectfully Submitted,

J. Dudley Hyde
Richard D. Nix
Mark D. Spencer*
**Counsel of Record*

McAfee & Taft
A Professional Corporation
Two Leadership Square
Tenth Floor
211 North Robinson Ave.
Oklahoma City OK 73102
(405) 235-9621

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In The

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GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

JOINT APPENDIX

JEFFREY S. POP*
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
9107 Wilshire Boulevard
Suite 600
Beverly Hills, California 90210
(310) 273-5462

Counsel for Respondents

JAMES F. JORDEN*
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, D.C. 20007
(202) 965-8100

THOMAS H. LAWRENCE
JOHN M. RUSSELL
HALE HEADRICK DEWEY WOLF GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

DAVID C. ASPINWALL
GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
8515 East Orchard Road
Englewood, Colorado 80111

Counsel for Petitioners

Counsel of Record

Petition For Certiorari Filed May 9, 2000
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DOCKET ENTRIES

LC022329

Los Angeles Superior Court

Janette Knudson, et al vs. Hyundai Motors of America

REGISTER OF ACTIONS

5/16/1994	ASC/TSC SET ON 8/16/94 AT 1:30PM IN NW"A"
6/27/1994	VAST DATE SET ON 9/28/94 AT 1:30PM IN NW"H"
8/16/1994	TRIAL SET ON 1/11/96 AT 9:00AM IN NW"A"
8/16/1994	ASC/TSC HELD
8/16/1994	MSC SET ON 12/11/95 AT 8:30AM IN NW"M"
8/17/1994	LAW & MOTION SET ON 11/04/94 AT 9:00AM IN NW"M"
9/28/1994	NOT SETTLED AT MSC
9/28/1994	TRIAL DATE STANDS
9/28/1994	VAST HEARING HELD
11/4/1994	MOTION GRANTED
11/4/1994	LAW & MOTION HELD
4/18/1995	LAW & MOTION SET ON 5/01/95 AT 9:00AM IN NW"Z"
5/1/1995	OFF CALENDAR
5/1/1995	LAW & MOTION HELD
11/20/1995	MINUTE ORDER PRODUCED

11/20/1995	LAW & MOTION SET ON 12/14/95 AT 9:00AM IN NW"Z"
11/20/1995	MSC DATE ADVANCED AND CONTINUED FROM 12/11/95 AT 8:30AM IN NW"M"
11/20/1995	MSC SET ON 12/11/95 AT 8:30AM IN NW"I"
11/21/1995	TRIAL DATE ON 1/11/96 AT 9:00AM IN NW"A" ADVANCED AND VACATED
11/21/1995	MSC DATE ON 12/11/95 AT 8:30AM IN NW"I" ADVANCED AND VACATED
11/21/1995	STATUS CONFERENCE SET ON 1/04/96 AT 1:30PM IN NW"A"
11/21/1995	MINUTE ORDER PRODUCED
12/1/1995	LAW & MOTION DATE ON 12/14/95 AT 9:00AM IN NW"Z" ADVANCED AND VACATED
1/4/1996	TRIAL SET ON 4/23/97 AT 9:00AM IN NW"A"
1/4/1996	STATUS CONFERENCE HELD
1/4/1996	MSC SET ON 3/13/97 AT 8:30AM IN NW"H"
1/16/1996	ANSWER TO CROSS COMPLAINT OF HYUNDAI MOTOR AMERICA, HYUNDAI MOTOR COMAPNY [sic] AND GALPIN MOTORS, LTD. FILED BY DAVID C. LEDERER (XDEFDNT) – REPRESENTING ERIC KNUDSON
6/14/1996	CHANGE OF ADDRESS FILED BY LAW OFFICES OF DAVID C. LEDERER (PLAINTIFF) – REPRESENTING ERIC KNUDSON.

3/7/1997	EX PARTE ORDER – APPLICATION FOR SHORTENING TIME, HELD. MSC & TRIAL DATES, CONTINUED. FILED BY JEFFREY S. POP (PLAINTIFF) – REPRESENTING JANETTE KNUDSON. FEES PAID $14.00 ORDER SIGNED BY THOMAS SCHNEIDER.
3/7/1997	MSC DATE ON 3/13/97 AT 8:30AM IN NW"H" ADVANCED AND VACATED
3/7/1997	TRIAL DATE ADVANCED AND CONTINUED FROM 4/23/97 AT 9:00AM IN NW"A"
3/7/1997	TRIAL SET ON 4/30/97 AT 9:00AM IN NW"A"
3/7/1997	MINUTE ORDER PROCESSED IN DEPARTMENT A
3/26/1997	PLAINTIFF, JANETTE KNUDSON, MOTION TO APPROVE SETTLEMENT AND PETITION FOR ORDER DIRECTING THE NET MONEY TO BE TO TRUST AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDICAL AND OTHER DISPUTED CREDITORS. $14.00 SET ON 4/23/1997 AT 9:00AM IN DEPARTMENT Z
4/22/1997	NOTICE OF REMOVAL FILED BY MCKINGHT, HUDSON, LEWIS (DEFENDANT) – REPRESENTING GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY.
4/23/1997	MOTION GRANTED
4/30/1997	STATUS RE REMOVAL FROM FEDERAL COURT AND SETTLEMENT CONTINUED

	TO 6/2/1997 AT 9:00AM IN DEPARTMENT A
6/2/1997	TRIAL CONTINUED TO 7/01/97 AT 9:00AM IN NW"A"
7/1/1997	TRIAL CONTINUED TO 9/03/97 AT 9:00AM IN NW"A"
7/7/1997	PLAINTIFF, JANETTE KNUDSON, MOTION FOR ORDER APPROVING SETTLEMENT AND PETITION DIRECTING THE NET MONEY TO BE PAID TO TRUST. $14.00 SET ON 7/23/1997 AT 9:00AM IN DEPARTMENT Z
7/22/1997	ORDER APPROVING SETTLEMENT AND PETITION DIRECTING THE NET MONIES TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (PROBATE CODE 3111) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDI-CAL AND OTHER DISPUTED CREDITORS (NWZ)
7/23/1997	MOTION GRANTED
8/14/1997	REQUEST FOR DISMISSAL WITH PREJUDICE AS TO COMPLT
8/14/1997	REQUEST FOR DISMISSAL WITH PREJUDICE AS TO XCOMPLT BY HYUNDAI MOTOR CO. FILED ON NOVEMBER, 1995
8/14/1997	REQUEST FOR DISMISSAL WITH PREJUDICE AS TO ENTIRE ACTION
8/14/1997	REQUEST OF DISMISSAL FILED
9/3/1997	OFF CALENDAR

97-CV-3745

U.S. District Court
Central District of California (Western Div.)

Great-West Life Ann. v. Janette Knudson, et al.

5/19/97	1	COMPLAINT filed Summons(es) issued referred to Discovery R. J. Groh (jp) [Entry date 05/20/97]
7/7/97	2	EX PARTE APPLICATION filed by plaintiff Great-West Life Ann for temporary restraining order (shb) [Entry date 07/08/97]
7/7/97	—	LODGED/ (3) PROPOSED ORDER submitted by plaintiff Great-West Life Ann for exparte motion for temporary restraining order [2-1]. (FWD TO CRD) (shb) [Entry date 07/08/97]
7/7/97	3	DECLARATION of Linda Claxton Johnson by plaintiff Great-West Life Ann in suppt of ex parte appl for tro [2-1] (shb) [Entry date 07/08/97]
7/7/97	4	MEMORANDUM of Points & Authorities by plaintiff Great-West Life Ann in support of exparte motion for temporary restraining order [2-1] (shb) [Entry date 07/08/97]
7/7/97	5	FIRST AMENDED COMPLAINT by plaintiff Great-West Life Ann Summons Issued on 1st Amd Cmp (shb) [Entry date 07/08/97]
7/8/97	7	OPPOSITION by defendant Eric Knudson to ex parte appl for tro [2-1]; Memo of Points & Authroities [sic]; Request for

monetary sanctions; Decl of David Lederer (shb) [Entry date 07/10/97]

7/8/97 7 REQUEST by defendant Eric Knudson for monetary sanctions (shb) [Entry date 07/10/97]

7/8/97 8 PROOF OF SERVICE by defendant Eric Knudson of Opposition to ex parte appl for tro; Memo of Points & Authorities and request for monetary sanctions; Decl of David Lederer served upon (See mailing list on original document) served on 7/8/97 via US mail (shb) [Entry date 07/10/97]

7/8/97 10 DECLARATION of Thomas H. Lawrence by plaintiff Great-West Life Ann in suppt of appl for tro [2-1], amd proposed ords [0-0] (shb) [Entry date 07/10/97]

7/9/97 6 ORDER by Judge James M. Ideman denying exparte motion for temporary restraining order [2-1]. (ENT 7/10/97), mld cpys & ntcs. (tw) [Entry date 07/10/97]

7/9/97 9 Jeffrey Pop's Special Appearance in OPPOSITION by defendant Janette Knudson to Request for TRO to pltfs appl for tro on behalf of dft Janette Knudson [2-1] (shb) [Entry date 07/10/97]

7/14/97 11 APPLICATION AND ORDER of Non-Resident Attorney to Appear in a Specific Case filed for plaintiff Great-West Life Ann by Thomas H Lawrence. Designating Linda Claxton as local counsel. Approved by Judge James M. Ideman – (Fee pd) (shb)

8/27/97 12 RETURN OF SUMMONS and proof of service of summons, first amended complaint and related documents executed upon defendant Janette Knudson on 8/20/97 via personal service (shb) [Entry date 08/28/97]

9/17/97 13 ANSWER filed by defendant Janette Knudson to first amnd complaint [5-1] (tw) [Entry date 09/18/97]

9/17/97 14 DEMAND for jury trial by defendant Janette Knudson (tw) [Entry date 09/18/97]

12/8/97 15 NOTICE OF MOTION AND MOTION by plaintiff Great-West Life Ann for leave to file second amended complaint; Memo of points and authorities; motion hearing set for 10:00 12/29/97 (shb) [Entry date 12/09/97]

12/8/97 — LODGED/PROPOSED ORDER submitted by plaintiff Great-West Life Ann for motion for leave to file second amended complaint [15-1]. (FWD TO CRD) (shb) [Entry date 12/09/97]

12/8/97 16 NOTICE OF MOTION AND MOTION by plaintiff Great-West Life Ann to strike jury demand; motion hearing set for 10:00 12/29/97 (shb) [Entry date 12/09/97]

12/8/97 17 MEMORANDUM by plaintiff Great-West Life Ann in support of motion to strike jury demand [16-1] (shb) [Entry date 12/09/97]

12/8/97 18 NOTICE OF MOTION AND MOTION by plaintiff Great-West Life Ann for preliminary injunction; motion hearing set for

10:00 12/29/97 (shb) [Entry date 12/09/97]

12/8/97 — LODGED Statement of facts submitted by plaintiff Great-West Life Ann (FWD TO CRD) (shb) [Entry date 12/09/97]

12/8/97 19 DECLARATION of Jerol J. Brown by plaintiff Great-West Life Ann in suppt of mot for preliminary injunction [18-1] (shb) [Entry date 12/09/97]

12/8/97 20 MEMORANDUM of points and authorities by plaintiff Great-West Life Ann in support of motion for preliminary injunction [18-1] (shb) [Entry date 12/09/97]

12/8/97 21 DECLARATION of Louis A Tuccitto by plaintiff Great-West Life Ann in suppt of mot for prelim inj [18-1] (shb) [Entry date 12/09/97]

12/8/97 22 DECLARATION of Pat Fry by plaintiff Great-West Life Ann re in suppt of mot for preliminary inj [18-1] (shb) [Entry date 12/09/97]

12/8/97 23 PROOF OF SERVICE by plaintiff Great-West Life Ann of verified second amd cmp; ntc of mot and mot for leave to file 2nd amd cmp; memo of points and authorities; ntc of mot and mot for pltfs for prel inj; decl of Louis Tuccitto in suppt; Decl of Pat Fry in suppt of mot for s/j; nt of mot and mot to str jury demand; memo of law in suppt of mot to strike jury demand . . . served upon Jeffrey Pop and Ms Louise Curinga on 12/8/97 by personal service. (shb) [Entry date 12/09/97]

12/9/97 24 ORDER by Judge James M. Ideman re oaral [sic] argument. Oral argument will be permitted in two exceptions: (a) when desired by the court and (b) when desired by counsel. In this case, cnsl shall file a request in writing for oral argument. This request must be suppt by a showing that oral arg is necessary under the particular circumstances of the case, and a further showing as to why the written briefs are inadequate to present cnsls position to the court. This request and showing shall be filed NLT 10 days before the hrg. The moving pty is ord to lodge with the crt proposed ords relating to the filed mot. This ord shall be loeged [sic] with the crt NLT 10 days after the filing of the mot. The ord shall contain a brief synopsis of the facts and applicable law suppt your mot. (shb) [Entry date 12/10/97]

12/9/97 27 NOTICE OF MOTION AND MOTION by plaintiff Great-West Life Ann for summary judgment; motion hearing set for 10:00 12/29/97 (shb) [Entry date 12/11/97]

12/9/97 28 MEMORANDUM of law by plaintiff Great-West Life Ann in support of motion for summary judgment [27-1] (shb) [Entry date 12/11/97]

12/10/97 25 ORDER by Judge James M. Ideman re oral argument. Oral argument will be permitted in two exceptions: (a) when desired by the court; and (b) when desired by cnsl. In this case, cnsl must fule [sic] a request in writing for oral arg. This req must be suppt by a showing that

oral arg is necessary under the particular circumstances of the case, and a further showing as to why the written briefs are inadequate to present cnsls position to the court. This request and showing shall be filed NLT 10 days before the hrg. The moving pty is ord to lodge with the crt proposed ords relating to the mot. The ord shall be lodged with the crt NLT 10 days after the filing of the mot. The order shall contain a brief synopsis of the facts and applicable law suppt your mot. (shb) [Entry date 12/11/97]

12/10/97 26 NOTICE OF DISCREPANCY AND ORDER by Judge James M. Ideman that the mot for s/j and suppt docs received on 12/9/97 is to be filed and processed. (shb) [Entry date 12/11/97]

12/10/97 29 STIPULATION for continuance of motion [27-1], re [18-1], re [16-1], re [15-1] (shb) [Entry date 12/12/97]

12/10/97 — LODGED/PROPOSED ORDER submitted by defendant Janette Knudson for stipulation [29-1]. (FWD TO CRD) (shb) [Entry date 12/12/97]

12/12/97 30 ORDER by Judge James M. Ideman resetting hearing on motion for summary judgment [27-1] 2/23/98, resetting hearing on motion for preliminary injunction [18-1] 2/28/98, resetting hearing on motion to strike jury demand [16-1] 2/28/98, resetting hearing on motion for leave to file second amended complaint [15-1] 2/28/98 (shb) [Entry date 12/15/97]

12/19/97 31 PROOF OF SERVICE mail by plaintiff Great-West Life Ann on 2/18/97 of ord re oral arg by mail to Leffrey [sic] S Pop, Esq. & Ms. Louise Curinga (kh) [Entry date 12/22/97] [Edit date 12/24/97]

1/13/98 32 ORDER by Judge James M. Ideman re oral arg. (ab) [Entry date 01/28/98]

1/13/98 33 NOTICE OF MOTION AND MOTION by plaintiff Great-West Life Ann to disqualify; motion hearing set for 10:00 2/2/98 (ab) [Entry date 01/28/98]

1/13/98 34 Memo of PA by plaintiff Great-West Life Ann to motion to disqualify [33-1] (ab) [Entry date 01/28/98]

1/20/98 35 Opp by defendant Janette Knudson to motion to disqualify [33-1] her atty; decl of Janette Knudson and Jeffrey S. Pop in suppt. (ab) [Entry date 01/28/98]

1/20/98 36 PROOF OF SERVICE by plaintiff Great-West Life Ann on 1/16/98 of oral arg. (ab) [Entry date 01/28/98]

1/28/98 47 STIPULATION and ORDER by Judge James M. Ideman resetting hearing on motion to disqualify [33-1] 2/23/98 NO TIME GIVEN AS TO THE CONTINUATION DATE; and plfs reply is due on 2-2-98. (AB) [Entry date 02/04/98]

2/2/98 37 NOTICE OF CROSS-MOTION AND CROSS-MOTION by defendant Janette Knudson for summary judgment against all pltfs on first amd cmp, or in the alt for summary adjudication of issues; motion hearing set for 2/23/98 (shb) [Entry date 02/03/98] [Edit date 02/03/98]

2/2/98 — LODGED/PROPOSED ORDER submitted by defendant Janette Knudson for motion for summary judgment against all pltfs on first amd cmp [37-1], for motion for summary adjudication of issues [37-2]. (FWD TO CRD) (shb) [Entry date 02/03/98]

2/2/98 — LODGED Statement of uncontroverted facts and conclusions of law submitted by defendant Janette Knudson (FWD TO CRD), (shb) [Entry date 02/03/98]

2/2/98 38 MEMORANDUM of points and authorities by defendant Janette Knudson in support of Cross-motion for summary judgment against all pltfs on first amd cmp [37-1], of motion for summary adjudication of issues [37-2] (shb) [Entry date 02/03/98] [Edit date 02/03/98]

2/2/98 39 REQUEST by defendant Janette Knudson for lodging (lodged orig depos) (shb) [Entry date 02/03/98]

2/2/98 40 REQUEST by defendant Janette Knudson for judicial ntc of prior case (shb) [Entry date 02/03/98]

2/2/98 41 APPENDIX OF EXHIBITS filed by defendant Janette Knudson for dfts cross motion for summary judgment and for dfts [37-1], Opposition to pltfs mot for summary jgm, declarative relief, and to file 2nd amd cmp [27-1] (VOL I OF IV) [Bates No. 00001 to 000196] (shb) [Entry date 02/03/98] [Edit date 02/03/98]

2/2/98 42 APPENDIX of Exhibits filed by defendant Janette Knudson for cross motion for

summary judgment [37-1], and for Opposition to pltfs mots for summary judgment, declarative relief and to file 2nd amd cmp [27-1] (VOL II of IV) [Bates No. 000197-000483] (shb) [Entry date 02/03/98]

2/2/98 43 APPENDIX of Exhibits filed by defendant Janette Knudson for dfts cross mot for summary judgment [37-1], and for opp to pltfs mot for summary judgment, decl relief, and to file 2nd amd cmp [27-1] (VOL III OF IV) [Bates No. 000484 to 000818] (shb) [Entry date 02/03/98]

2/2/98 44 APPENDIX OF EXHIBITS filed by defendant Janette Knudsonfor [sic] dfts cross mot for summary jgm [37-1], and for dfts Opposition to pltfs summary jgm, declarative relief, and to file 2nd amd cmp [27-1] (VOL IV OF IV) [Bates No. 000819 to 001138] (shb) [Entry date 02/03/98] [Edit date 02/03/98]

2/2/98 45 PROOF OF SERVICE by defendant Janette Knudson on 2/2/98 of appendix of exhibits for dfts cross mot for s/j and for dfts opp to pltfs mor for s/j; declarative relief and to file 2nd amd cmp served upon Linda Claxton Johnson by personal service (shb) [Entry date 02/03/98]

2/2/98 46 PROOF OF SERVICE by defendant Janette Knudson on 2/2/98 of append of exhs for dfts cross mot for s/j and for opp to pltrsmots for s/j, decl rel, and to file 2nd amd cmp served upon Thomas Lawrence by express mail (shb) [Entry date 02/03/98)

2/3/98	48	ORDER by Judge James M. Ideman re ORAL ARGUMENT. Oral arg willbe [sic] permitted in 2 exceptions: (a) when desired by the crt and (b) when desired by cnsl. In this case cnsl shall file a request in writing for oral argument. This request must be suppt by a showing that oral arg is necessary under the particular circumstances of the case, and a further showing as to why the written briefs are inadequate to present cnsls position to the crt. This request and showing shall be filed NLT 10 days before the hrg. The mov pty is ord to lodge with the crt proposed ords relating to the filed mot. This ord shall be lodged with the crt NLT 10 days agftger [sic] the filing of the mot. The ord shall contain a br synopsis of the facts and applicable law suppt your mot. (shb) [Entry date 02/04/98]
2/3/98	49	Reply by plaintiff Great-West Life Ann to motion to dfts opposition to motion to disqualify [33-1] (shb) [Entry date 02/05/98]
2/9/98	50	OPPOSITION by defendant Janette Knudson to motion/req for preliminary injunction [18-1] (ab) [Entry date 02/11/98]
2/9/98	51	OPPOSITION by defendant Janette Knudson to motion to strike jury demand [16-1] (ab) [Entry date 02/11/98]
2/9/98	52	EVID OBJECTIONS by defendant Janette Knudson to the decl of Jerol Brown and Patricia Fry and mot to strike such evid as well to strke [sic] ref to unpublished cases attached to plfs mot for S/J and arg thereon. (ab) [Entry date 02/11/98]

2/9/98	52	REQUEST/MOTION by defendant Janette Knudson to strike such evid as well to strike ref to unpublished cases attached to plfs mot for S/J and arg thereon. (ab) [Entry date 02/11/98]
2/9/98	53	P&A IN OPPOSITION by defendant Janette Knudson to motion for summary judgment [27-1] (ab) [Entry date 02/11/98]
2/9/98	54	STATEMENT genuine issues in opp by defendant Janette Knudson to motion for summary judgment [27-1]; and stmt of facts and conclusions of law in opp to pfls mot for S/J; decl of David Lederer Esq. (ab) [Entry date 02/11/98]
2/9/98	55	DECLARATION of Jeffrey S. Pop by defendant Janette Knudson (ab) [Entry date 02/11/98]
2/9/98	56	OPPOSITION by defendant Janette Knudson to motion for leave to file second amended complaint [15-1]; memo of PA. (ab) [Entry date 02/11/98]
2/12/98	58	PROOF OF SERVICE by defendant Janette Knudson on 2/12/98 of ord re: oral arg. (ab) [Entry date 02/23/98]
2/13/98	57	STIPULATION for cont of ntc of mot for lv to file 2nd a/C; mot for P/I; mot to strike Jury dmd; and mot for plfs W/J and mot for dfts crs mot for S/J. (ab) [Entry date 02/23/98]
2/13/98	—	LODGED/PROPOSED ORDER submitted by defendant Janette Knudson for stipulation [57-1]. (FWD TO CRD) (ab) [Entry date 02/23/98]

2/13/98 59 STIPULATION of facts btween the ptys. (ab) [Entry date 02/23/98]

2/13/98 61 NOTICE by plaintiff Great-West Life Ann of change of firm name and firm affiliation for plf atty. (ab) [Entry date 02/26/98]

2/20/98 60 ORDER by Judge James M. Ideman resetting hearing on motion for summary judgment against all pltfs on first amd cmp [37-1] 3/23/98, resetting hearing on motion for summary adjudication of issues [37-2] 3/23/98 NO TIME GIVEN AS TO THE CONTINUATION DATES GIVEN both w/out prej to either of the ptys req this crt for a cont upon good cause shown. (ab) [Entry date 02/24/98]

3/9/98 66 DECLARATION of Thomas H. Lawrence by plaintiff Great-West Life Ann re motion for summary jugment against all pltfs on first amd cmp [37-1] (ab) [Entry date 03/13/98]

3/10/98 62 NOTICE by defendant Janette Knudson of ldging orig depo transc of Louis A. Tuccitto. (ab) [Entry date 03/13/98]

3/10/98 — LODGED 2 depos submitted by defendant Janette Knudson (FWD TO CRD) (ab) [Entry date 03/13/98]

3/10/98 63 RESPONSE by plaintiff Great-West Life Ann to to [sic] motion for summary judgment against all pltfs on first amd cmp [37-1] (ab) [Entry date 03/13/98]

3/10/98 64 SUPPL DECLARATION of Jerol J. Brown by plaintiff Great-West Life Ann re motion for summary judgment against all

pltfs on first amd cmp [37-1] (ab) [Entry date 03/13/98]

3/10/98 65 STATEMENT genuine issues purs to L/R 7.14.2 by plaintiff Great-West Life Ann re motion for summary judgment against all pltfs on first amd cmp [37-1] (ab) [Entry date 03/13/98]

3/10/98 67 Table Contents and table of auth re resp by plaintiff Great-West Life Ann to motion for summary judgment against all pltfs on first amd cmp [37-1] (ab) [Entry date 03/13/98]

3/13/98 68 NOTICE by plaintiff Great-West Life Ann of lodging depo transcr (tw) [Entry date 03/17/98]

3/16/98 70 DECLARATION of Thomas H. Lawrence by plaintiff Great-West Life Ann in suppt of plfs replies re motion for summary judgment [27-1], motion for preliminary injunction [18-1] (tw) [Entry date 03/19/98]

3/16/98 71 Second Suppl DECLARATION of Jerol J. Brown by plaintiff Great-West Life Ann (tw) [Entry date 03/19/98]

3/16/98 72 DECLARATION of Louis A. Tuccitto by plaintiff (tw) [Entry date 03/19/98]

3/16/98 73 REPLY by plaintiff Great-West Life Ann to Knudson's opp to motion for summary judgment [27-1] (tw) [Entry date 03/19/98]

3/16/98 74 REPLY by plaintiff to dft's opp to plfs motion for preliminary injunction [18-1], motion for leave to file second amended

		complaint [15-1] (tw) [Entry date 03/19/98]
3/16/98	75	REPLYbrief [sic] & points & authorities by defendant Janette Knudson supporting Knudson's X motion for summary judgment [37-1] (tw) [Entry date 03/20/98]
3/17/98	69	Errata to plfs REPLY by plaintiff Great-West Life Ann to Knudson's opp to plfs' motion for summary judgment [27-1] (tw) [Entry date 03/19/98]
3/23/98	76	RESPONSE by plaintiff Great-West Life Ann to dfts evidentiary objs [52-1] (tw) [Entry date 03/26/98]
3/26/98	77	OBJECTIONS by defendant Janette Knudson to pltfs response to evidentiary objections as untimely to and improper submission of suppl decl [76-1] (shb) [Entry date 03/27/98]
4/16/98	78	RESPONSE by plaintiff Great-West Life Ann to dfts obj to plfs resp to evidentiary objs as untimely & improper submissions of suppl decls [77-1] (tw) [Entry date 04/17/98]
5/18/98	79	ORDER by Judge James M. Ideman granting motion for summary judgment [37-1]. (ENT 5/20/98) mld cpys & ntc (pbap) [Entry date 05/20/98]
5/18/98	80	STATEMENT of of Uncontroverted Facts and Concl of Law by defendant Janette Knudson in support of [37-1]. (ENT 5/20/98) mld cpys & ntc (pbap) [Entry date 05/20/98]
5/18/98	81	JUDGMENT by Judge James M. Ideman S/J has been grntd in favor of Dfts in this

		case. It is hereby adj that Plfs take nothing by their cmp. terminating case. (ENT 5/20/98) MD JS 6 mld cpys & ntc (pbap) [Entry date 05/20/98]
6/3/98	82	NOTICE by defendant Janette Knudson of appearance to tax costs (tw) [Entry date 06/04/98]
6/3/98	83	MEMORANDUM of PA by defendant Janette Knudson in support of Bill of cost notice [82-1] (tw) [Entry date 06/04/98]
6/3/98	84	BILL OF COSTS RETURNABLE submitted by defendant Janette Knudson re [81-2]; bill of cost hearing set on 9:00 6/22/98 (tw) [Entry date 06/04/98]
6/3/98	85	NOTICE OF MOTION AND MOTION by defendant Janette Knudson for attorney fees; motion hearing set for 10:00 7/6/98 (lc) [Entry date 06/05/98]
6/3/98	86	MEMORANDUM IN SUPPORT by defendant Janette Knudson of motion for attorney fees [85-1] (lc) [Entry date 06/05/98]
6/4/98	87	MOTION by plaintiff Great-West Life Ann to reconsideration ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt; motion hearing set for 10:00 7/6/98 (tw) [Entry date 06/08/98]
6/4/98	88	MEMORANDUM IN SUPPORT by plaintiff Great-West Life Ann of motion to reconsideration ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt [87-1] (tw) [Entry date 06/08/98]
6/4/98	90	ORDER re oral argument by Judge James M. Ideman (tw) [Entry date 06/08/98]

6/5/98	89	ORDER Re: Oral argument by Judge James M. Ideman (tw) [Entry date 06/08/98]
6/10/98	91	NOTICE re order [90-1] (ap) [Entry date 06/12/98]
6/15/98	92	DECLARATION of Thomas H Lawrence by plaintiff Great-West Life Ann re motion to reconsideration ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt [87-1] (el) [Entry date 06/16/98]
6/19/98	93	NOTICE by plaintiff Great-West Life Ann of filing alternative proposed orders (tw) [Entry date 06/22/98]
6/22/98	94	RESPONSE by plaintiff Great-West Life Ann in opp to motion for attorney fees [85-1] (el) [Entry date 06/23/98]
6/22/98	95	MEMORANDUM of PA by defendant Eric Knudson in opposition to motion to reconsideration ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt [87-1] (el) [Entry date 06/23/98]
6/24/98	—	COSTS taxed for defendant Janette Knudson in the amount of $4,981.62 against plaintiff Great-West Life Ann (cc: all counsel); bill of cost hearing held. (ab) [Entry date 06/26/98]
6/29/98	97	MEMORANDUM of PA by defendant Janette Knudson in support of motion for attorney fees [85-1]; decl of Richard S MacNaughton Esq (el) [Entry date 07/10/98]
6/29/98	98	REPLY by plaintiff Great-West Life Ann to response to motion to reconsideration

ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt [87-1] ~~(el)~~ [Entry date 07/10/98]

7/9/98	96	ORDER by Judge James M. Ideman denying motion to reconsideration ord gr dft's mot for sum jgmt & deny plfs' mot for sum jgmt [87-1], granting motion for attorney fees [85-1] (ENT 7/10/98), mld cpys & ntcs. (tw) [Entry date 07/10/98]
8/7/98	99	NOTICE OF APPEAL/REPRESENTATION STATEMENT by plaintiffs Great-West Life Ann; Earth System, Inc.; Health & Welfare Plan for Employees of Earth Systems, Inc., to 9th C/A from Dist. Court ord ent 7/10/98 [96-1], jgm ent 5/20/98 [81-2] (cc: Lewis Fisher Henderson & Claxton; Jeffrey S. Pop & Associates) Fee: Paid. (ghap)

98-56472

U.S. Court of Appeals for the Ninth Circuit

Great-West Life v. Knudson, et al.

3/22/00 Filed order (Betty B. FLETCHER, Harry PREGERSON, Charles R. Weiner): The panel has voted unanimously to deny the petition for rehearing. Judge Pregerson voted to deny the petition for rehearing en banc and Judges B. Fletcher and Weiner so recommended. The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed.R.App.P.35. The petition for rehearing is denied and the petition for rehearing en banc is rejected. [3853283-1] [98-56472] (cha)

3/28/00 Filed Appellant Great-West Life Annu's motion to stay the mandate. [98-56472] served on 3/27/00 [PANEL] [98-56472] (mhf)

3/28/00 Filed Aplts' mtn for reconsideration of denial of pet for rhrg en banc & Notice of Addl Authority in support of; [98-56472] served on 3/17/00 [PANEL] [98-56472] (mhf)

4/3/00 Filed order (Betty B. FLETCHER, Harry PREGERSON, Weiner): The appellees' request for attorneys' fees on appeal is denied. [3861327-1] [98-56472] (cha)

4/4/00 Filed order (Betty B. FLETCHER): Appellants Motion to Stay the Mandate is granted. The mandate shall reissue nintey [sic] (90) days from the date this order, unless appellants file a petition for a writ of certiorari in the Supreme Court and give notice to our Clerk is

writing within said ninety day period. In that case, the mandate shall remain withdrawn until the Supreme Court's final disposition. [3878384-1] [98-56472] (cha)

4/10/00 Filed Appellant's mtn to direct clk's office to distribute aplt's mtn for reconsideration of denial of pet for rhrg en banc to all active judges [98-56472] served on 3/27/00 [PANEL] [98-56472] (mhf)

5/15/00 Received notice from Supreme Court: petition for certiorari filed Supreme Court No. 99-1786 filed on 5/9/00. [98-56472] (dg)

2/1/01 Received notice from Supreme Court, petition for certiorari GRANTED on 1/22/01. Supreme Court No. 99-1786 (PANEL by fax) (dg)

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. Plaintiffs v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	Case No.: CV 97-3745 JMI (JGx)

SERVICES AGREEMENT

This Agreement entered into on JANUARY 1, 1990.

Between
THE GREAT-WEST LIFE ASSURANCE COMPANY,
hereinafter referred to as "GREAT-WEST"

and

EARTH SYSTEMS, INC.

hereinafter referred to as "the Contractholder."

Whereas the Contractholder has established a Health Care Payment Plan or Health Care Payment Plan and

Trust for the benefit of its Employees and Dependents (hereinafter referred to as the "Plan");

And Whereas the Plan is an employee benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 and the undersigned fiduciary (hereinafter referred to as the "Fiduciary") of the Plan hereby retains GREAT-WEST to provide services for the Plan in accordance with the following terms and conditions:

Article I – Definitions

In this Agreement unless otherwise specifically provided:

(1) "Dependent" and "Employee" mean dependent and employee as defined by the Plan;

(2) Anniversary Date, Agreement Months and Agreement Years shall be calculated from JANUARY 1, 1990; JANUARY 1 of any year shall be known as the Anniversary Date;

(3) "Agreement Year" means that period of 12 consecutive months which begins on the Anniversary Date.

Article II – Administrative Services and Fees

GREAT-WEST agrees to perform such services involving the performance of non-discretionary duties as are specified in the Schedule of Services marked Schedule "A", which is attached hereto and forms part of this Agreement in accordance with the terms and conditions of this Agreement.

To facilitate the performance of such duties:

(1) GREAT-WEST has established a Central Disbursement Account with the Colorado National Bank, Denver, Colorado (CNB); and

(2) the Contractholder has advised its bank that CNB is authorized to demand moneys payable to GREAT-WEST by the Contractholder for checks cashed for benefit payments made by GREAT-WEST under the Plan. CNB is authorized to do this through the Central Disbursement Account established by GREAT-WEST; and

(3) GREAT-WEST will advise CNB of the amounts which are to be withdrawn from the Contractholder's designated bank account. The Contractholder agrees to maintain funds in such account which are adequate to cover benefit payments made by GREAT-WEST under the Plan.

The Contractholder and Fiduciary agree to pay GREAT-WEST the fees specified in the Schedule of Fees marked Schedule "B" which is attached hereto and forms part of this Agreement as reasonable compensation for services necessary for the Plan's operation. The Contractholder and Fiduciary shall be jointly and severally liable for the payment of such fees. Such fees shall be paid as described in the attached Schedule B. A grace period of 30 days shall be granted for each payment of fees falling due after the first payment during which period this Agreement shall remain in force. If any payment is not made within the days of grace, this Agreement shall automatically terminate. If this Agreement terminates for any reason, the Contractholder and Fiduciary shall be liable for all payments due and unpaid, including a pro-rata payment

for any time this Agreement is in force during the grace period.

Note: A Float Amount, as shown in Schedule B, will be payable by the Contractholder to GREAT-WEST with the first payment. GREAT-WEST will annually determine adjustments to the Float Amount. Such adjustments are to be paid within 31 days after the beginning of each Agreement Year. The Float Amount will be credited to the Contractholder after the date of termination of this Agreement.

Article III – Furnishing of Information; Access to Records

The Contractholder and Fiduciary shall furnish GREAT-WEST, on request, with correct and complete information required by GREAT-WEST to provide the services which GREAT-WEST has agreed to perform under this Agreement, including, but not limited to, a copy of the Plan and any amendments thereto. The information shall be furnished at the times and in such manner as GREAT-WEST may request. GREAT-WEST shall assume that all such information is complete and accurate and shall be under no duty to question the accuracy of such information. The files and other records of GREAT-WEST with respect to the Plan shall be the property of GREAT-WEST. GREAT-WEST, at its discretion, may charge additional fees for its services where information is not furnished, is incomplete or inaccurate or is not furnished at the time or in the manner as requested. The Contractholder agrees to give GREAT-WEST the right to inspect the records of the Contractholder which are pertinent to the operation of the Plan.

All communications sent to the Contractholder or Fiduciary from GREAT-WEST shall be transmitted to the Contractholder at the address appearing below or to such other person and address as may from time to time be designated by the Contractholder in writing. Notice transmitted to the Contractholder as aforesaid shall be considered received by the Contractholder and Fiduciary and notice sent to GREAT-WEST shall be directed to the address shown below or to such other address as GREAT-WEST may designate in writing from time to time.

Article IV – Authority to Control and Manage the Plan

The Contractholder and Fiduciary acknowledge that they have authority to control and manage the operation of the Plan. It is expressly agreed that under no circumstances shall GREAT-WEST be designated as plan administrator or a fiduciary of the Plan. Nothing herein shall be deemed to constitute GREAT-WEST a party to the Plan or to confer upon GREAT-WEST any authority or control respecting management of the Plan, authority or responsibility in connection with administration of the Plan or responsibility for the terms or validity of the Plan. GREAT-WEST shall not be responsible for any tax liability which may be imposed upon the Contractholder, any fiduciary or any Employee or Dependent under the Plan. The Contractholder and Fiduciary further agree that nothing herein shall be deemed to impose upon GREAT-WEST any obligation to any Employee or Dependent under the Plan.

Article V – Indemnification and Limitation of Liability

The Contractholder and Fiduciary shall indemnify, protect and hold GREAT-WEST harmless from any loss, liability, claim or expense (including attorneys' fees, court costs and expenses of litigation) arising out of any act or omission of the Contractholder or Fiduciary in connection with the Plan. Any premium or other tax assessed against GREAT-WEST in respect of the Plan, including any accrued interest and penalties levied on such tax, shall be borne by the Contractholder.

GREAT-WEST hereby agrees to reimburse the Contractholder and hold the Contractholder harmless in the case of a default by a representative of GREAT-WEST against the designated account of the Contractholder.

In no event shall incorrect determination of any benefit be the responsibility of GREAT-WEST.

Article VI – Agreement Termination

This Agreement may be terminated at any time by either the Contractholder and Fiduciary or GREAT-WEST provided written notice of such termination is given at least 31 days in advance. In addition, GREAT-WEST may terminate this Agreement immediately upon:

(1) amendment of the Plan in a manner deemed unsatisfactory by GREAT-WEST, provided that GREAT-WEST provides 31 days' written notice of such termination to the Contractholder.

(2) failure of the Contractholder to comply with any term or condition of this Agreement such as but not limited to failure to honor demands for fund by GREAT-WEST and/or CNB.

In the event of termination of this Agreement, GREAT-WEST shall have the right to stop processing claims immediately on the effective date of such termination. Complete information regarding all outstanding claims which are unpaid or received after such date shall be returned by GREAT-WEST to the Contractholder. In addition, GREAT-WEST shall have the right to notify each Employee covered under the Plan of such termination. To facilitate such notification the Contractholder shall, upon request, provide GREAT-WEST with a list of the name and home address of each Employee concerned. Such information must be provided to GREAT-WEST within 31 days after termination of this Agreement.

Article VII – Amendment of Schedule of Fees

GREAT-WEST has the right to revise the Schedule of Fees:

(1) when the Plan is amended, and

(2) after the first anniversary of the Effective Date of this Agreement but not more than once in any 12 month period, and

(3) when the services described in the Schedule of Services are changed.

Article VIII – Entire Agreement

This instrument contains the entire Agreement between the parties and sets forth in full the services to be rendered by GREAT-WEST. It may only be modified or amended by written agreement of the parties hereto and any representation or statement not expressly set forth

hereunder shall not be binding on any party hereto in any respect.

EARTH SYSTEMS, INC.
1900 EMBARCADERO ROAD
SUITE 207
PALO ALTO, CALIFORNIA 94303

By /s/ [Illegible] Treasurer 2/27/90
Signature Title Date

[Illegible] Plan Administrator 2/27/90
Fiduciary Signature Title Date

2275 E. Bayshore Rd. Palo Alto CA 94303
Mailing Address of Fiduciary

THE GREAT-WEST LIFE ASSURANCE COMPANY

By /s/ [Illegible] Asst. Mgr., 1/19/90
Signature Title Date

Tower 1, Great-West Life Center
8505 E. Orchard Road
Englewood, CO 80111

SERVICES AGREEMENT
SCHEDULE A – SCHEDULE OF SERVICES

The following services will be provided for the administration of the Contractholder's Plan.

Drafting Assistance
– Booklet
– Booklet Amendments
Standard Allowance for Booklet printing
I.D. Card Preparation
Standard Allowance for I.D. Card printing
Preparation of enrollment procedures
Assistance in plan enrollment
Late applicant underwriting
Claim form preparation
Standard Allowance for Claim form printing
Check preparation
Standard Allowance for Check printing
Benefit determination in accordance with the Plan
Benefit payments in accordance with the Plan
Claims Reports:
– Monthly detail list of plan payments
– Monthly summary by benefit type
– Run-off studies
Bank Reconciliation listing
Preparation of Physician payment reports
Actuarial cost estimates:
– Open and Unreported claims liabilities
– Review of Past Experience
– Projection of future cost
– Legislated changes in benefits
– Plan modifications

Expenses incurred by Great-West Life for services not covered or for covered services beyond standard allowances will be charged as incurred.

GREAT-WEST LIFE ASSURANCE COMPANY

/s/ [Illegible]
Authorized Signature

EARTH SYSTEMS, INC.

/s/ [Illegible], Treasurer
Authorized Signature

THE GREAT-WEST LIFE ASSURANCE COMPANY
US HEADQUARTERS
ENGLEWOOD COLORADO

APPLICATION FOR GROUP CONTRACT

EARTH SYSTEMS, INC.

(the Applicant) hereby applies to The Great-West Life Assurance Company for **Group Contract No. 39004GSL** in the form attached hereto. This Group Contract has been approved and its terms accepted by the Applicant.

Dated at Palo Alto, CA this 27th day of February

EARTH SYSTEMS, INC.

/s/ [Illegible]
Witness

BY /s/ [Illegible]

Treasurer
Title

/s/ [Illegible]
Licensed Resident Agent

STOP-LOSS CONTRACT

THE GREAT-WEST LIFE ASSURANCE COMPANY (herein called Great-West) in consideration of the application of

EARTH SYSTEMS, INC.
(herein called the Contractholder)

and in consideration of the payment of premiums as herein provided, hereby agrees to pay to the Contractholder the benefits as provided herein.

This contract shall be effective from **JANUARY 1, 1990** (herein called the Effective Date).

This contract is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

All provisions set forth on the following pages form a part of this contract as fully as if the same were stated over the signatures hereto.

IN WITNESS WHEREOF the Company has caused this contract to be executed at its U.S. Headquarters.

/s/ [Illegible]
Senior Vice-President and Secretary

/s/ K.P. Kavanagh
President

/s/ [Illegible]
For the Actuary

Group Health Insurance
GSL-M1

Contract Form No. GSL-M184

Group Contract No. 39004GSL

ARTICLE 1 – Definitions

(1) "Plan" means that portion of the Contractholder's employee health benefit plan which is

(A) administered by Great-West; and

(B) referred to in section (5) of this Article 1 as "Coverages" provided under the Plan and covered by this contract; and

(C) in effect on the Effective Date of this contract

Any amendments accepted by Great-West which are made to the Plan from time to time while this contract is in effect are also included.

(2) "Dependent" and "Employee" and "Employee Class" are as defined in the Plan.

(3) "Contract Year" is any period of 1 year beginning on an anniversary of the Effective Date, except that the last Contract Year will end upon termination of this contract. If on the date of termination of this contact the Terminal Attachment Factor shown in Schedule "A" is other than "Not Applicable", then the last Contract Year will also include any months after termination of this contract in which there are any Benefit Payments.

(4) "Contract Months" are consecutive periods of 1 month, except that the last Contract Month terminates at the end of the last Contract Year. The first Contract Month begins on the Effective Date.

(5) "Coverages" provided under the Plan and covered by this contract are:

Hospital and Medical Coverage
Dentalcare Coverage

(6) "Exposure" for a Coverage and Contract Month and Employee Class is the number of Employees

in that Employee Class having that Coverage under the Plan during the third prior Contract Month. For the first four Contract Months, Exposure for a Coverage and Employee Class is the number of Employees having that coverage under the Plan during the first Contract Month.

Note: The term "Employees" as used in this definition shall include Employees and/or eligible Dependents whose coverage under the Plan is being continued under the COBRA HEALTH CONTINUATION provision which forms a part of the Plan.

(7) "Monthly Attachment Factor" for a Coverage is as shown in Schedule "A"

(8) "Terminal Attachment Factor" for a Coverage is as shown in Schedule "A"

(9) "Aggregate Limitation Factor" is as shown in Section "A"

(10) "Premium Factor" for a Coverage is as shown in Schedule "A"

(11) "Monthly Attachment Level" means

(A) for a Contract Month prior to termination of this contract, the sum for all Coverages and Employee Classes of the product of the Monthly Attachment Factor multiplied by the Exposure.

(B) for the first three Contract Months after termination of this contract, the sum for all Coverages and Employee Classes of the product of the Terminal Attachment Factor multiplied by the Exposure.

(C) for any other Contract Month, not applicable

(12) "Cumulative Attachment Level" for a Contract Month in a Contract Year is the sum of the Monthly Attachment Level for the Contract Month and the Monthly Attachment Levels for all previous Contract Months in the Contract Year.

(13) "Specific Stop Loss Level" is as shown in Schedule "A"

(14) "Benefit Payments" for a Contract Month means the sum of the amounts of all checks paid as benefits for expenses incurred after the effective date of this contract under the Plan during the Contract Month, less any benefits paid by Great-West to the Contractholder pursuant to Article 2 of this contract. Checks are considered paid when presented for payment at a bank designated by Great-West.

(15) "Specific Loss" is calculated each Contract Year for each Employee and each Dependent. It is the sum of the checks issued as benefits for expenses incurred after the Effective Date of this contract under the Hospital and Medical Coverage of the Plan for all Contract Months prior to termination of this contract in the Contract Year with respect to the Employee or Dependent.

(16) "Accumulated Benefit Payments" for a Contract Month in a Contract Year means the sum of Benefit Payments for the Contract Month and the Benefit Payments for all previous Contract Months in the Contract Year.

(17) "Experience Deficit" for the first Contract Month means any aggregate stop loss benefits paid by Great-West to the Contractholder pursuant to Article 3 of this Contract for the first Contract Month. For any succeeding Contract Month, "Experience

Deficit" means the excess of the sum of (A) and (B) over (C) where

(A) is the Experience Deficit for the previous Contract Month,

(B) is any aggregate stop loss benefits paid by Great-West to the Contractholder pursuant to Article 3 for the Contract Month and

(C) is any reimbursement made by the Contractholder to Great-West pursuant to Article 3 for the Contract Month,

except that in no event will the Experience Deficit for the last Contract Month in any Contract Year exceed the sum of (D) and (E) where:

(D) is the Experience Deficit for the last Contract Month of the previous Contract Year; and

(E) is the product of the Aggregate Limitation Factor and the Cumulative Attachment Level for the Contract Year.

ARTICLE 2 – Specific Stop Loss Benefit

For each Employee and each Dependent, Great-West will pay the Contractholder a benefit equal to the excess, if any, of the Specific Loss for the Contract Year over the Specific Stop Loss Level.

Article 3 – Aggregate Stop Loss Benefit

(1) For each Contract Month in a Contract Year, Great-West will pay the Contractholder a benefit equal to the excess if any of the sum of (A) and (B) over the sum of (C) and (D) where:

(A) is the Accumulated Benefit Payments for the Contract Month;

(B) is the sum of any reimbursements made by the Contractholder to Great-West pursuant to section 2 of this Article 3 for any prior Contract Months in the Contract Year;

(C) is the Cumulative Attachment Level for the Contract Month; and

(D) is the sum of any aggregate stop loss benefits paid by Great-West to the contractholder pursuant to this Article 3 for any prior Contract Months in the Contract Year.

This payment will be made after the end of each Contract Month.

(2) At the end of every Contract Month in a Contract Year, the Contractholder will reimburse Great-West for the lesser of (A) and (B), where,

(A) is the Experience Deficit for the previous Contract Month;

(B) is the excess if any of (a) over (b), where

(a) is the Monthly Attachment Level for the Contract Month; and

(b) is the Benefit Payments for the Contract Month

ARTICLE 4 – Premiums

The premium to each Contract Month prior to termination of this contract is equal to the sum for all Coverages and Employee Classes under the Plan of the product of the Premium Factor multiplied by the number of Employees covered during that Contract Month.

The premium for the first Contract Month following termination of this Contract is equal to the sum for all Coverages and Employee Classes under the Plan of the product of the Terminal Premium Factor shown in Schedule "A" multiplied by the number of Employees covered during the last month prior to termination of this contract.

There will be an additional premium each month with respect to each Employee or Dependent issued medical insurance under section (2) of Article 9 during the month. These premiums will be determined by Great-West.

A grace period of 31 days shall be granted for the payment of each premium falling due after the first premium, during which period this contract shall remain in force. If any premium is not paid within the grace period this contract shall automatically terminate. If this contract terminates for any reason, the Contractholder shall be liable for all premiums due and unpaid, including a pro rata premium for any time this contract is in force during the grace period.

ARTICLE 5 – Administration of the Plan, Access to Information

Great-West will make payments for the benefits provided under the terms of the Plan. In no event will the amounts paid for investigation of or defense against claims be included in determining the Specific Loss and Accumulated Benefit Payments for a Contract Year.

The Contractholder or his agent shall furnish monthly to Great-West the Exposure for such Contract Month.

Great-West shall have the right to inspect the records of either the Contractholder or his agent which are pertinent to the operation of the Plan or which are pertinent to determination of the Exposure or the amount of the Specific Loss or the Accumulated Benefit Payments.

ARTICLE 6 – Amendments and Alterations

(1) Unless otherwise indicated the factors shown in Schedule "A" are for the first Contract Year.

(2) After the end of the first Contract Year, Great-West may change the factors shown in Schedule "A" on any premium due date, but not more frequently than once in each Contract Year except as provided in (3) below.

(3) A change in factors can be made at any time during the first or subsequent Contract Years

(A) if the coverage provided under the Contractholder's Plan is changed; or

(B) if the provisions of the Contractholder's Plan have to be changed because of a change in law; or

(C) if there is a change in the number of Employees covered under the Contractholder's Plan which exceeds

(a) 10% in any Contract Month, or

(b) 25% over any period of 3 consecutive Contract Months; or

(D) upon addition or deletion of coverage for subsidiary or affiliated companies or corporate divisions

ARTICLE 7 – Contract Termination

This contract may be terminated by either the Contractholder or Great-West by providing 31 days' notice of such termination to the other party.

In addition, Great-West may terminate this contract immediately upon,

(1) termination of the Services Agreement between Great-West and the Contractholder; or

(2) failure of the Contractholder to comply with any term or condition of this contract.

If any state or other jurisdiction enacts or amends a law or regulation which, in the opinion of Great-West prohibits the continuance of this contract, the contract shall terminate in respect of that jurisdiction. Termination of the contract shall take place on the effective date of the law, regulation or amendment as determined by Great-West.

ARTICLE 8 – Parties to the Contract

The parties to this contract shall be the Contractholder and Great-West. This contract shall not create any rights or obligations whatsoever on the part of Great-West with respect to the persons covered under the Plan, or their beneficiaries.

ARTICLE 9 – Miscellaneous

(1) The Contractholder agrees to indemnify Great-West and hold Great-West harmless against any premium tax or other tax assessed against Great-West in respect of Plan benefits.

(2) A covered Employee or Dependent under age 65 whose medical Coverage under the Plan ends due to:

(A) termination of employment;

(B) termination of employment in an eligible class;

(C) change in marital status (in the case of a Dependent);

(D) attainment of the limiting age specified in the Plan (in the case of a Dependent child); or

(E) death of the Employee (in the case of a Dependent).

will be entitled to purchase medical insurance from Great-West. This medical insurance is referred to as Health Conversion Coverage. If such covered Employee has Dependents who are also covered under the Plan, the Health Conversion Coverage may also cover such Dependents.

Issuance of the Health Conversion Coverage will be subject to all of the following conditions:

(A) No evidence of insurability is required.

(B) The Employee or Dependent is not eligible for Medicare.

(C) The Employee or Dependent is not covered by or eligible for similar benefits, as a result of termination of his medical coverage, under any policy, contract, or other arrangement for group insurance benefits or services.

(D) Written application and the first premium for the Health Conversion Coverage must be delivered or mailed to Great-West at its home office within 31 days after the date on which

the covered Employee or Dependent's medical coverage under the Plan terminates.

(E) The Health Conversion Coverage provides coverage customarily issued by Great-West at the then current rates. Benefits provided under the Health Conversion Coverage are not the same as those provided by the Plan.

(F) The Health Conversion Coverage is effective on the next day after the date on which coverage under the Plan ceases.

STOP-LOSS CONTRACT
SCHEDULE A

The Level and Factor shown below apply to all Employees in all Employee Classes

Specific Stop Loss Level	$25,000.00
Aggregate Limitation Factor	10.00%

The Coverages and Factors applicable to each Employee Class are shown below:

Employee Class	Coverages	Factors
ALL NON-COLLECTIVE BARGAINING EMPLOYEES	Monthly Attachment Factor for All Coverages:	$192.77
	Terminal Attachment Factor for All Coverages:	$285.47
	Premium Factor for All Coverages:	$44.34
	Terminal Premium Factor for All Coverages:	$42.40

NOTE: As used herein, "Dependent Unit" means all covered Dependents of a Covered Employee.

Notwithstanding anything to the contrary expressed or implied herein, Great-West shall have the sole right to make claims under the Right of Recovery Provision contained in the Plan. In its sole discretion Great-West may litigate, negotiate, settle, compromise, release or waive any such claim. The Contractholder hereby assigns to Great-West all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim.

Action taken under the Right of Recovery Provision contained in the Plan may result in the incurral of legal expenses. Such legal expenses will be borne by Great-West and the Contractholder in the same proportion as any money recovered under the Right of Recovery Provision is distributed between Great-West and the Contractholder. If no money is recovered, the legal expenses will be borne by Great-West and the Contractholder in the same proportion that each party's share of claims paid bears to the total amount of claims paid.

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

Case No. CV 97-3745 JMI (JGx)

[Caption Omitted In Printing]

Attached to and forming part of
Group Contract No. 39004GSL
issued by
THE GREAT-WEST LIFE ASSURANCE COMPANY

to
EARTH SYSTEMS, INC.

This Contract is hereby amended as of JANUARY 1, 1991

(1) by deleting items (6) and (11) of ARTICLE 1 – Definitions and substituting the following:

(6) "Exposure" for a Coverage and Contract Month and Employee Class is the number of Employees in that Employee Class having that Coverage under the Plan during the second prior Contract Month. **NOTE:** The term "Employees" as used in this definition shall include Employees and/or eligible Dependents whose coverage under the Booklet/Certificate is being continued under the COBRA HEAI TH CONTINUATION provision which forms a part of the Booklet/Certificate.

(11) "Monthly Attachment Level" means:

(a) for a Contract Month prior to termination of this contract, the sum for all Coverages and Employee Classes of the product of the Monthly Attachment Factor multiplied by the Exposure.

(b) for the first two Contract Months after termination of this contract, the sum for all

Coverages and Employee Classes of the product of the Terminal Attachment Factor multiplied by the Exposure.

(c) for any other Contract Month, not applicable.

(2) by deleting SCHEDULE A and replacing it with the attached SCHEDULE A.

Dated at Englewood, Colorado this 21st day of March, 1991.

THE GREAT-WEST LIFE ASSURANCE COMPANY

/s/ D. C. [Illegible]
Senior Vice-President,
General Counsel and
Secretary

/s/ K P Kavanagh
President

/s/ L [Illegible]
For the Actuary

Accepted and attached to the Contract by EARTH SYSTEMS, INC. this 20th day of May, 1991.

BY /s/ [Illegible]
TITLE Trustee

STOP-LOSS CONTRACT
SCHEDULE A

The Level and Factor shown below apply to all Employees in all Employee Classes:

Specific Stop Loss Level	$75,000.00
Aggregate Limitation Factor	10.00%

The Coverages and Factors applicable to each Employee Class are shown below:

Employee Class	Coverages	Factors
ALL EMPLOYEES	Monthly Attachment Factor for All Coverages:	$364.73
	Terminal Attachment Factor for All Coverages:	$733.10
	Premium Factor for All Coverages:	$44.34
	Terminal Premium Factor for All Coverages:	$72.59

Notwithstanding anything to the contrary expressed or implied herein, Great-West shall have the sole right to make claims under the right of Recovery Provision contained in the Plan. In its sole discretion Great-West may litigate, negotiate, settle, compromise, release or waive any such claim. The Contractholder hereby assigns to Great-West all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim.

Action taken under the Right of Recovery Provision contained in the Plan may result in the incurral of legal expenses. Such legal expenses will be borne by Great-West and the Contractholder in the same proportion as any money recovered under the Right of Recovery Provision is distributed between Great-West and the Contractholder. If no money is recovered, the legal expenses will be borne by Great-West and the Contractholder in the same proportion that each party's share of claims paid bears to the total amount of claims paid.

All money recovered by Great-West under the Right of Recovery Provision will be distributed as follows:

(1) first, to Great-West to be applied to reduce Great-West's payments of Specific Stop Loss Benefits to the Contractholder pursuant to Article 2 of this Contract;

(2) secondly, to Great-West to be applied to reduce Great-West's payments of aggregate stop loss benefits to the Contractholder pursuant to Article 3 of this Contract; and

(3) thirdly, to the Contractholder.

All money recovered will be applied to the accounting for the Contract Year in which the claim giving rise to subrogation was paid. If claim expenses were paid in more than one Contract Year, the money will be applied on a pro rata basis in accordance with the amount of claim expenses paid in each of the Contract Years.

The Contractholder hereby assigns to Great-West any and all rights the Contractholder, as Employer, may have under the Right of Recovery Provision contained in the Plan.

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 97-3745 JMI (JGx)
[Caption Omitted In Printing]

Attached to and forming part of
Group Contract No. 39004GSL

issued by
THE GREAT-WEST LIFE ASSURANCE COMPANY

to
EARTH SYSTEMS, INC.

This Contract is hereby amended as of AUGUST 1, 1991 by deleting SCHEDULE A and replacing it with the attached SCHEDULE A.

Dated at Englewood, Colorado this 29th day of August, 1991.

THE GREAT-WEST LIFE ASSURANCE COMPANY

/s/ D. C. [Illegible]
Senior Vice-President,
General Counsel and
Secretary

/s/ K P Kavanagh
President

/s/ [Illegible]
For the Actuary

Accepted and attached to the Contract by EARTH SYSTEMS, INC. this 16th day of September, 1991.

BY /s/ [Illegible]
TITLE VICE PRESIDENT

STOP-LOSS CONTRACT
SCHEDULE A

The Level and Factor shown below apply to all Employees in all Employee Classes:

Specific Stop Loss Level	$75,000.00
Aggregate Limitation Factor	10.00%

The Coverages and Factors applicable to each Employee Class are shown below:

Employee Class	Coverages	Factors
EMPLOYEES COVERED UNDER THE GREAT-WEST CARE PLAN	Monthly Attachment Factor for All Coverages:	$364.73
	Terminal Attachment Factor for All Coverages:	$733.10
	Premium Factor for All Coverages:	$44.34
	Terminal Premium Factor for All Coverages:	$72.59
EMPLOYEES COVERED UNDER THE GREAT-WEST CARE EXCLUSIVE PLAN	Monthly Attachment Factor for All Coverages:	$305.64
	Terminal Attachment Factor for All Coverages:	$614.34

Premium Factor for All Coverages:	$38.33
Terminal Premium Factor for All Coverages:	$60.83

Notwithstanding anything to the contrary expressed or implied herein, Great-West shall have the sole right to make claims under the Right of Recovery Provision contained in the Plan. In its sole discretion Great-West may litigate, negotiate, settle, compromise, release or waive any such claim. The Contractholder hereby assigns to Great-West all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim.

Action taken under the Right of Recovery Provision contained in the Plan may result in the incurral of legal expenses. Such legal expenses will be borne by Great-West and the Contractholder in the same proportion as any money recovered under the Right of Recovery Provision is distributed between Great-West and the Contractholder. If no money is recovered, the legal expenses will be borne by Great-West and the Contractholder in the same proportion that each party's share of claims paid bears to the total amount of claims paid.

All money recovered by Great-West under the Right of Recovery Provision will be distributed as follows:

(1) first, to Great-West to be applied to reduce Great-West's payments of Specific Stop Loss Benefits to the Contractholder pursuant to Article 2 of this Contract;

(2) secondly, to Great-West to be applied to reduce Great-West's payments of aggregate stop loss benefits to the Contractholder pursuant to Article 3 of this Contract; and

(3) thirdly, to the Contractholder.

All money recovered will be applied to the accounting for the Contract Year in which the claim giving rise to right of recovery was paid. If claim expenses were paid in more than one Contract Year, the money will be applied on a pro rata basis in accordance with the amount of claim expenses paid in each of the Contract Years.

The Contractholder hereby assigns to Great-West any and all rights the Contractholder, as Employer, may have under the Right of Recovery Provision contained in the Plan.

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

Case No. CV 97-3745 JMI (JGx)

[Caption Omitted In Printing]

EARTH SYSTEMS, INC.

SUMMARY PLAN DESCRIPTION

EXCERPT OF SUMMARY PLAN DESCRIPTION

JANUARY 1, 1992 IV-4 HOW TO FILE CLAIMS

CO-ORDINATION OF BENEFITS (COB)

The COB provision is designed to correct overcoverage which occurs when a person has health coverage for the same expenses under two or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be co-ordinated with those of the other plans so that, the total benefits from all plans will not exceed the expenses actually incurred.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

- This Plan;
- Any other group insurance or prepayment plan, Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law.

ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the first of the following rules which applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a **Dependent** will determine its benefits before a plan that covers such person as a **Dependent.**
- When a claim is made for a **Dependent** child who is covered by more than one plan:
  - the benefits of the plan of the parent whose birthday falls earlier in a year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but
  - if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before [IV-5] those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule". The Birthday Rule will be used to determine the order of benefits for **Dependent** children in all cases except those described below.

- If the other plan does not have the Birthday Rule, then the plan which covers the child as a **Department** of the male parent will pay its benefits first.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:

- first, the plan of the parent with custody of the child will pay its benefits;
- then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
- finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a **Dependent** of that parent will determine its benefits before any other plan.

- A plan that covers a person as:
  - a laid-off **Employee**; or
  - a **Retired Employee**; or
  - a **Dependent** of such **Employee**;

  will determine its benefits **after** the plan that does not cover such person as:
  - a laid-off **Employee**; or
  - a **Retired Employee**; or
  - a **Dependent** of such **Employee**.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

[IV-6] • If none of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for

coverage under the new plan within 24 hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g. single employer plan to multiple employer plan) **will not** constitute the start of a new plan.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, **Usual and Customary** item of expense at least part of which is covered under at least one of the plans covering the person for whom claim is made or service provided. In no event will Allowable Expense include the difference between the cost of a private hospital room and a semi-private hospital room unless the patient's stay in a private hospital room is **Medically Necessary**.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

[IV-7] PROVISION FOR RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a **Covered Person** for:

- an illness; or
- a sickness; or
- a bodily injury.

When this happens we will, subject to all other terms and provisions of this **Booklet**, pay any benefits which are payable for the expenses incurred by the **Covered Person** for the treatment of such illness, sickness or bodily injury (the Loss).

RIGHT OF RECOVERY

We will, at our sole option, have the right to recover from the **Covered Person** any payment for benefits paid for treatment of such Loss under this **Booklet** which the **Covered Person** is entitled to receive from the third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the **Covered Person** receives from:

- the third party; or
- the third party's insurer or guarantor; or
- the **Covered Person's** uninsured motorist insurance.

This lien will not exceed:

- the amount of benefits paid under this **Booklet** for the treatment of the Loss; or
- the amount received by the **Covered Person** for such medical treatment from the third party.

[IV-8] CONDITIONS

- The **Covered Person** must cooperate fully with us in asserting our right to recover. If the **Covered Person**:
  - makes any recovery as set forth in this provision; and
  - fails to reimburse us fully for any benefits paid under this provision;

  then he will be personally liable to us to the extent of such recovery up to the amount of the first lien.
- Before any benefits are paid for treatment of such Loss under this **Booklet**, we may require the **Covered Person** to provide all information and sign and return all documents necessary to exercise our rights under this provision.

DENIAL OF CLAIM

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by the Plan Administor before the end of the initial 90-day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described below.

[IV-9] APPEAL OF A CLAIM DENIAL

If there are any questions about a claim payment, the Plan Administrator should be contacted. If it is desired to initiate a claim review procedure because there is disagreement with the reasons why the claim was denied, the Plan Administrator should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

DECISION ON REVIEW

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which event a further 60 days will be allowed.

[IV-10] ERISA GENERAL INFORMATION

- Name of Plan:

  Health and Welfare Plan for **Employees** of EARTH SYSTEMS, INC.,

- Policyholder/**Employer**:

  EARTH SYSTEMS, INC.
  5880 W. LAS POSITAS BLVD.
  SUITE 52
  PLEASANTON, CALIFORNIA 94588

- Employer Identification Number (EIN) assigned to the Plan Sponsor by IRS:

  94-2742060

  Plan number assigned by the Plan Sponsor/**Employer**:

  501

- Type of Plan:

  Life Insurance
  Accidental Death, Dismemberment and Loss of Sight Insurance
  Hospital Benefits
  Medical Benefits
  Dentalcare Benefits
  Prescription Drug Benefits
  Flexible Benefits Account

- Funding:

  Great-West Life & Annuity Insurance Company completely funds the following benefits:

  Life Insurance
  Accidental Death, Dismemberment and Loss of Sight Insurance

[IV-11] The **Employer** completely funds the following benefits:

Hospital Benefits
Medical Benefits
Dentalcare Benefits
Prescription Drug Benefits

- Type of Administration:

  Contract Administration

- Plan Administrator:

  DENISE SHELTON
  HUMAN RESOURCES MANAGER
  EARTH SYSTEMS, INC.
  5880 W. LAS POSITAS BLVD.
  SUITE 52
  PLEASONTON, CALIFORNIA 94588
  800-870-0991

- Agent for service of legal process:

  Plan Administrator (see above)

- The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this **Booklet**.

- The sources of contributions to the plan:

Employee Coverages –	0% Employee	100% Employer
Dependent Coverages –	20% Employee	80% Employer
Flexible Benefits Account –	100% Employee	0% Employer

- The date of the end of the year for purposes of maintaining the plan's fiscal records:

  DECEMBER 31

- [IV-12] Claims – The procedures to be followed in presenting claims for benefits under the plan and the remedies for the redress of claims which are denied in whole or in part are described in this **Booklet**.

- Statement of ERISA Rights:

  As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

  – Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

  – Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

  – Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the **Employee** benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your **Employer**, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare

benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may [IV-13] require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g. if it finds your claim is frivolous). If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

RIGHTS

If **Retired Employees** are covered under the Plan described in this **Booklet**, then the term **"Employee"** will include a **Retired Employee.**

Employee Rights

Employees' rights under the plan are legally enforceable as long as **Employees** meet the eligibility requirements. **Employees** will have continued rights upon plan termination with regard to claims incurred prior to termination.

[IV-14] Employer Rights

The benefits for **Employees** are intended to be effective for an indefinite period of time. However, the **Employer** reserves the right to modify or terminate the plan at will, except with regard to claims incurred prior to modification or termination. Modification includes but is not limited to the **Employer's** right to change the nature or extent of benefits provided or his **Employees'** contributions to the Plan.

OTHER GENERAL INFORMATION

CALIFORNIA LAW REQUIRES THAT THE FOLLOWING INFORMATION BE PROVIDED TO ALL EMPLOYEES LOCATED IN CALIFORNIA.

IF YOU HAVE A COMPLAINT CONCERNING A CLAIM AND YOU HAVE BEEN UNABLE TO RESOLVE THE COMPLAINT SATISFACTORILY THROUGH CONTACT

WITH GREAT-WEST, ITS AGENTS OR REPRESENTATIVES, THEN YOU MAY SEEK ASSISTANCE BY CALLING OR WRITING TO THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE ADDRESS OR TELEPHONE NUMBER SHOWN BELOW:

UNDERWRITING DIVISION
CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET,
LOS ANGELES, CA 90013

TOLL-FREE TELEPHONE NO: 1-800-927-HELP (4357)

Linda Claxton, Esq. (State Bar No. 125729)
LEWIS FISHER HENDERSON & CLAXTON, PLLC
12100 Wilshire Boulevard, Suite 600
Los Angeles, California 90025
(310) 820-3150

Thomas H. Lawrence, Esq. (TN Bar No. 017105)
LEWIS FISHER HENDERSON & CLAXTON, PLLC
5050 Poplar Avenue, Suite 1717
Memphis, Tennessee 38157
(901) 767-6160

Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., Plaintiffs, v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	Case No. CV 97-3745 JMI (JGx) DECLARATION OF LOUIS A. TUCCITTO (Honorable James M. Ideman) Date: Time: Ctrm:

I, Louis A. Tuccitto, declare as follows:

1. I am an Associate Manager in the Great-West Life & Annuity Insurance Company ("Great-West") Recovery Unit. I have personal knowledge of the facts stated herein and if called as a witness I could and would competently testify to those facts.

2. Great-West initially contacted Eric Knudson on august 19, 1992 seeking the name of he and Janette Knudson's attorney and informing them of the Plan's right to full reimbursement to the extent of benefits paid if third parties were made. A true and correct copy of correspondence sent by Great-West to Eric Knudson is attached hereto as Exhibit 1.

3. Eric Knudson responded to that letter and Great-West received the response on September 4, 1992. A true and correct copy of the handwritten note received from Eric Knudson in response to Great-West's August 19, 1992 letter is attached hereto as Exhibit 2.

4. On September 30, 1992, I sent Janette Knudson a letter advising her that Great-West, on behalf of the Plan, had a first-lien Right of Recovery to any sums paid in settlement or judgment on her behalf as a result of her accident. A true and correct copy of the letter I sent to Janette Knudson, along with the Right of Recovery Agreement and Recovery Questionnaire I enclosed are attached hereto as Exhibit 3.

5. In that correspondence, I requested that "[I]n conformance with the plan documents [that she] please complete and return the Recovery Questionnaire and Right of Recovery Agreement." *Id.*

6. Ms. Knudson was advised that "failure to respond accurately and promptly may affect future benefits." *Id.*

7. The letter also stated that if she had an attorney, this correspondence as well as its enclosures should be sent to [her] attorney immediately for completion and return. *Id.* The letter also provided information that Janette Knudson needed in order to completely and accurately fill out the RRA, such as the Plan number and the "Legaleze" number, Great-West's internal tracking number. *Id.*

8. If Eric Knudson had not signed this document, Ms. Knudson would have been violating the terms of the Plan and the Plan would not have been obligated to pay benefits on her behalf.

9. The Plan paid benefits on her behalf in consideration of Eric Knudson executing the RRA on her behalf.

10. Under the terms of the SPD, Ms. Knudson was required to "sign and return all documents necessary to exercise our rights under this provision."

11. As required by the SPD, Eric Knudson returned the completed Recovery Questionnaire and RRA to Great-West. Great-West received these documents on October 29, 1992. A true and correct copy of the completed Recovery Questionnaire and signed Right of Recovery Agreement is attached as Exhibit 4.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 13, 1998.

/s/ Louis A. Tuccitto
Louis A. Tuccitto

Great-West LIFE & ANNUITY *INSURANCE COMPANY*

AUGUST 19, 1992

RGNL,218,052556,071,S549062458,** REPLY TO:

ERIC KNUDSON
18646 SUNBURST STREET
NORTHRIDGE CA 91324

SAN FRANCISCO
BENEFIT PAYMENTS
455 MARKET STREET
SUITE 2000
SAN FRANCISCO CA
94105
TELE. 800 685 1040

RE: EMPLOYEE: ERIC KNUDSON S549062458
PATIENT: JANETTE SP
PLAN NO.: 052556 CLAIM NO: 500

WE ARE WRITING TO INFORM YOU THAT YOUR GROUP HEALTH CONTRACT ALLOWS YOUR GROUP HEALTH PLAN TO BE A PARTY TO ANY LEGAL ACTION YOU MAY TAKE BECAUSE OF AN ACCIDENT OR INJURY.

THIS MEANS THAT IF YOU RECEIVE A SETTLEMENT OR JUDGEMENT FROM THE COURT, THE PLAN IS ENTITLED TO FULL REIMBURSEMENT FOR EXPENSES WHICH WERE PAID ON YOUR BEHALF.

IF YOU RETAIN AN ATTORNEY AS PART OF THE SETTLEMENT OR JUDGEMENT PROCESS, HE IS NOT AUTHORIZED TO REPRESENT THE GROUP HEALTH PLAN OR THIS COMPANY UNLESS HE HAS BEEN SPECIFICALLY RETAINED BY THIS COMPANY'S RECOVERY UNIT. ALSO, NO PART OF THE GROUP HEALTH PLAN'S RECOVERY WILL BE CONTRIBUTED TOWARD YOUR ATTORNEY'S LEGAL FEES.

SO THAT WE MAY MORE ACCURATELY HANDLE YOUR CLAIMS PROCESS, PLEASE PROVIDE THE FOLLOWING INFORMATION TO THIS COMPANY'S RECOVERY UNIT, 6T2, 8515 E. ORCHARD ROAD, ENGLEWOOD, CO 80111:

1. NAME AND ADDRESS OF YOUR ATTORNEY AND YOUR INSURER (OTHER THAN THIS COMPANY).
2. NAME AND ADDRESS OF THE THIRD PARTY'S ATTORNEY AND INSURER.

A COPY OF THIS LETTER AND COPIES OF CLAIMS YOU'VE SUBMITTED HAVE BEEN SENT TO OUR RECOVERY UNIT. WE WILL CONTACT YOU IF WE NEED ANY FURTHER INFORMATION.

THANK YOU IN ADVANCE FOR YOUR ATTENTION AND ASSISTANCE.

BENEFIT PAYMENTS OFFICE

021878-218

DAVID C. LEDERER

Attorney at Law

12424 Wilshire Boulevard, Suite 830
Los Angeles, California 90025

Telephone (310) 820-5012
Facsimile (310) 820-5502

[Handwritten In Original

RE: ERIC KNUDSON S549-06-2458
PATIENT: JANETTE SP
PLAN NO.: 052556 CLAIM NO: 500]

[Following Enclosed Material Was Marked "Void N/A" –
Re:

Doctor:_____
Report Number:
Other:

TO WHOM IT MAY CONCERN:

This will authorize you to release to us, the LAW OFFICES OF DAVID LEDERER, or a representative, all information, including copies or photostats or photographs of any and all medical, hospital, police, or other reports, records, x-rays, or other information, relating to the events or the injuries and/or damages sustained by the undersigned, arising out of the incident which occurred on _____ at or near _____.

_____
Signed:]

[Note Handwritten In Original]

PLEASE NOTE ABOVE ADDRESS AND PHONE OF MY "ATTORNEY OF RECORD" RE: THIS INCIDENT AND

PENDING LAWSUIT. HE HAS BEEN INFORMED OF THIS AND WILL BE HAPPY TO COOPERATE IN ANY WAY POSSIBLE.

P.S. PARDON THE INFORMALITY.

/s/ Eric Knudson

RGNL. 218, 052556, 071, S549062458

Great-West Life

[Address Omitted In Printing]

CERTIFIED/RETURN RECEIPT REQUESTED

September 30, 1992

Janette Knudson
18646 Sunburst Street
Northridge, CA 91324

Re: *Right of Recovery*
Claimant: Janette Knudson
Plan Name: Earth System
Plan #52556-071
Legaleze #073917

Dear Ms. Knudson:

The Recovery Unit has been forwarded claims information from the San Francisco Benefit Payment Office with regard to claims paid on your behalf as a result of injuries sustained on or about June 10, 1992. The Great-West Life Assurance Company on behalf of its Planholder, Earth System, Plan #52556-071, is investigating the Plan's recovery possibilities from potential sources such as the liable third party, third party insurer or other insurance.

Please be advised that The Great-West Life Assurance Company on behalf of the Plan has a first lien Right of Recovery to any sums paid in settlement or judgment on your behalf as a result of the accident. The claims information indicates that at least $9,049.00 has been paid to hospital and medical providers on your behalf as a result of the accident.

In conformance with the Plan documents please complete and return the Recovery Questionnaire and Right of

Recovery Agreement. Please provide a copy of the accident report or at least a narrative description of the accident. The Questionnaire should be completed to the best of your ability and returned along with a signed Reimbursement Agreement within 10 days from receipt of this correspondence. Failure to respond accurately and promptly may affect future benefits.

If you have retained an attorney to represent you in settlement negotiations or in litigation with regard to this matter, this correspondence as well as its enclosures should be sent to your attorney immediately for completion and return. Settlement of this matter in contravention to the above does not extinguish the Plan's rights in this matter or reduce its legal options.

Correspondence regarding this matter should be sent to the above address, Attn: Recovery Unit, 7T2. Please be sure to refer to our Legaleze #073917 in any correspondence. Direct telephone inquiries may be made at (303) 689-4290.

Sincerely,

/s/ Louis A. Tuccitto
Louis A. Tuccitto
Assistant Manager
Recovery Unit

Enclosures

bpc: San Francisco Benefit Payment Office
Referencing Employee ID #549-06-2458

Please refer to the above Legaleze #073917 on any future correspondence or submissions. Thank you!

LEGALEZE #073917

RIGHT OF RECOVERY AGREEMENT

Plan name: EARTH SYSTEMS INC. Plan number: 052556-071

Employee's name: ERIC KNUDSON Patient's name: JANETTE KNUDSON

Social Security Number: 549-06-2458 Date of the Injury: 6/10/92

As a member of the above named Plan, I have made a claim for covered medical expenses under the terms of the Plan for myself or dependent for the injury/illness as detailed above. I understand that a claim for similar expenses may be covered under other Plans, such as Auto Accident Insurance, Student Health Insurance, Workers' Compensation, or Homeowners Insurance.

I request that benefits be paid by the Plan at this time without the necessity of awaiting final determination of responsibility and with the understanding that no benefits may be payable and that another party or insurer may be liable for like benefits for which they will make payments.

In consideration for the plan paying benefits and in accordance with the terms of the Plan, I agree that the plan may be subrogated to me or my dependent's rights for any benefits from the other party. I agree to transfer to the Plan any right I or my dependents may have to take legal action against the other party. I also agree to cooperate fully with the Plan in asserting its right to subrogate and supply to the Plan any and all information. I will execute all documents reasonably necessary to carry out

its right to recover from the other party any benefits paid under the Plan which are subject to this provision.

I also understand that under the terms of the Plan, the Plan may recover from me any payment for benefits paid under this Plan for which I or my dependents may be entitled to receive from a third party. The Plan shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise, that I or my dependents receives from another party, the other party's insurer or guarantor, or my own insurer or guarantor. Said first lien shall be for the amount of medical and hospital benefits paid by the Plan, I shall be personally liable to the Plan to the extent of such recovery up to the amount of its first lien. I agree to cooperate fully with the Plan in asserting its rights to recover.

Dated: 10/20/92 Signature: /s/ Eric Knudson
(Employee or Non-minor dependent)

RECEIVED
OCT 29 1992

RECOVERY QUESTIONNAIRE

LEGALEZE #073917

:NSURED'S NAME: ERIC KNUDSON

SSN 549-06-2458

?LAN NAME EARTH SYSTEMS INC.

?LAN NUMBER 052556-071

:OCATION OF ACCIDENT INTERSTATE – 5 (SOUTH-BOUND NEAR KETTLEMAN

?LEASE PROVIDE THE ACCIDENT REPORT OR A WRITTEN NARRATION OF HOW THE INCIDENT OCCURRED, AND THE FOLLOWING INFORMATION:

VEHICLE STEERING FAILURE – ROLLED VEHICLE

	YOU	OTHER PARTY
NAME	ERIC KNUDSON	
ADDRESS	18646 SUNBURST ST NORTHRIDGE, CA. 91324	

INSURANCE COMPANY
(other than Great-West Life or TNE)
INSURERS ADDRESS
STATE FARM INS.
31303 AGURA RD.
WESTLAKE VILLAGE, CA. 91363

ADJUSTOR'S NAME JOELLE MONTAG (818) 703-5823

POLICY NUMBER
945-1654

CLAIM NUMBER
75-2533-203

ATTORNEY
DAVID LEDERER (310) 820-5012

ATTORNEY'S ADDRESS
12424 WILSHIRE BLVD. #830

LOS ANGELES, CA. 90025

HAS LAWSUIT BEEN FILED? _____. IF YES, PLEASE STATE COURT AND ENCLOSE COPY OF COMPLAINT

_____

HAVE YOU BEGUN SETTLEMENT NEGOTIATIONS? NO. IF YES, PLEASE GIVE DETAILS. _____

P:WP50\CMF\RECOVERY.QUE

*PRODUCTS LIABILITY SUIT, IS PEND

[Proof Of Service Omitted In Printing]

Thomas L. Henderson, TN Bar No. 11526
Thomas H. Lawrence, TN Bar No. 17105
McKNIGHT HUDSON LEWIS/
FORD & HARRISON LLP
6750 Poplar Ave., Suite 301
Memphis, Tennessee 38138
(901) 756-1550

Linda Claxton Johnson, CA Bar No. 125729
FORD & HARRISON LLP
333 South Grand Avenue
Suite 3680
Los Angeles, California 90071
(213) 680-4161

Attorneys for Plaintiff
Great-West Life & Annuity Insurance Company

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, Plaintiff, v. JANETTE KNUDSON, ~~an individual~~ [AND ERIC KNUDSON] Defendant.	CASE NO 97-3745JMI (JGx) COMPLAINT (Filed May 19, 1997)

Plaintiff Great-West Life & Annuity Insurance Co. ("Great-West"), pleads as follows:

1. This action to enforce the terms of the Health and Welfare Plan for Employees of Earth Systems, Inc. (the "Plan") and for equitable relief arises under the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461. Declaratory relief is also sought pursuant to 28 U.S.C. §§ 2201 and 2202.

PARTIES

2. Plaintiff Great-West Life & Annuity Insurance Company is the assignee for collection of the Health and Welfare Plan for Employees of Earth Systems, Inc. for the purpose of prosecuting all rights and claims for reimbursement and, as such, is authorized to bring this action within the meaning of 29 U.S.C. § 1132(a)(2) and (a)(3)(B)(ii).

3. Defendants Janette Knudson and Eric Knudson are citizens and residents of Los Angeles County, California.

JURISDICTION AND VENUE

4. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132 because this action to enforce provisions of the Plan arises under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

5. Pursuant to 29 U.S.C. § 1132(e)(2), venue is proper in this Court because Defendants reside in this district and because the breach of Plan provisions have occurred and are occurring in this district.

FACTUAL ALLEGATIONS

6. Defendant Eric Knudson was an employee of Earth Systems, Inc. He elected to participate in the Plan for purposes of obtaining medical, surgical, and hospital benefits for himself and for his wife Janette Knudson, as such, Janette Knudson, is a "covered person" under the Health and Welfare Plan for Employees of Earth Systems, Inc. (the "Plan")

7. On or about June 10, 1992, Plaintiff was involved in an automobile accident. As a result of the accident, Plaintiff asserted a claim for personal injuries against Honda Motors of America, Inc., Galpin Motors, Inc. and Hyundai Motor Company.

8. In connection with the same injures alleged in that claim, the Plan paid medical benefits to the Plaintiffs in the amount of $411,157.11.

9. The Plan maintains an express provision for right of recovery which states:

> A third party may be liable or legally responsible for expenses incurred by a covered person for
>
> an illness; or a sickness; or a bodily injury.
>
> When this happens we will, subject to all other terms and provisions of this booklet, pay any benefits which are payable for the expenses incurred by the covered person for the treatment of such illness, sickness or bodily injury. (The loss).
>
> RIGHT OF RECOVERY. We will, at our sole option, have the right to recover from the covered person any payment for benefits paid for

treatment of such loss under this booklet which the covered person is entitled to receive from a third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the covered person receives:

The third party;

or the third party's insurer or guarantor;

or the covered person's uninsured motorists insurance.

This lien will not exceed:

the amount of benefits paid under this booklet for the treatment of a loss;

or

the amount received by the covered person for such medical treatment from the third party.

CONDITIONS:

The covered person must cooperate fully with us in asserting our right to recover. If the covered person: – makes any recovery as set forth in this provision; and – fails to reimburse us fully for any benefits paid under this provision; then he will be personally liable to us the extent of such recovery up to the amount of the first lien.

before any benefits are paid for the treatment of such loss under this booklet, we may require the covered person to provide all information and sign and return all documents necessary to exercise our rights under this provision.

10. Defendants settled their claims for $650,000.00. Plaintiff has requested assurance that Defendants will

honor the terms of the Plan, but Defendants have failed and refused to provide such assurances.

I. INJUNCTION AGAINST ACTS AND PRACTICES THAT VIOLATE THE TERMS OF THE PLAN

11. Pursuant to 29 U.S.C. § 1132(a)(3), Plaintiff seeks an injunction against Defendants: (1) to prevent the Defendants from violating the terms of the Plan and (2) to enforce the terms of the Plan.

12. By not agreeing to reimburse the Plan the amount recovered, Defendants have violated, and therefore breached the terms of the Plan.

13. Since this act and/or practice violates the Plan's terms, this Court should enter an order enjoining Defendants and all of those persons in active concert or participation with them, from violating the Plan's terms.

14. Specifically, the Court should enjoin Defendants and all those in active concert or participation with them, to reimburse the Plan in the amount of $411,157.11 out of any proceeds they recovered from third parties.

II. DECLARATORY RELIEF

15. Pursuant to 28 U.S.C. §§ 2201, 2202, Plaintiffs request that the Court order and declare that:

A. The terms of the Plan provide for full reimbursement from Plan participants and their beneficiaries for sums paid by the Plan to the participants and/or their beneficiaries which the participant or beneficiary is able to recover from third parties;

B. Defendants are required to reimburse the Plan in the amount of $411,157.11 out of any proceeds Defendants recovered from responsible third parties.

PRAYER FOR RELIEF

Plaintiff requests that it be granted an injunction against acts and practices that violate the terms of the Plan and declaratory judgment against Defendants enforcing the terms of the Plan. Additionally, Defendants, and those acting in active concert or participation with them, should be enjoined to reimburse the Plan for the amount Defendants recovered from responsible third parties, up to $411,157.11. Plaintiff seeks an award of attorneys' fees for having to bring this action. Plaintiff also seeks prejudgment and postjudgment interest at the highest legal rate.

DATED: May 19, 1997

Respectfully submitted,

FORD & HARRISON LLP

By: /s/ Linda Claxton Johnson
Linda Claxton Johnson

McKNIGHT HUDSON LEWIS
FORD & HARRISON LLP

By: /s/ Thomas L. Henderson
Thomas L. Henderson

By: /s/ Thomas H. Lawrence
Thomas H. Lawrence

[Exhibits Omitted In Printing]

Thomas H. Lawrence, TN Bar No. 17105
JACKSON, LEWIS, SCHNITZLER
& KRUPMAN
2311 Cedar Springs Road, Suite 400
Dallas, Texas 75201-7812
(214) 220-0025

Linda Claxton Johnson, CA Bar No. 125729
FORD & HARRISON LLP
333 South Grand Avenue
Suite 3680
Los Angeles, California 90071
(213) 680-3410

Thomas L. Henderson, TN Bar No. 11526
McKNIGHT HUDSON LEWIS/
FORD & HARRISON LLP
6750 Poplar Ave., Suite 301
Memphis, Tennessee 38138

Attorneys for Plaintiffs
Great-West Life & Annuity Insurance
Company, the Health and Welfare Plan
for Employees of Earth Systems, Inc., and
Earth Systems, Inc., the Plan
Administrator for the Health and Welfare
Plan for Employees of Earth Systems, Inc.

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH	))))))	CASE NO. CV 97-3745 JMI(JGx) **VERIFIED FIRST AMENDED COMPLAINT**

SYSTEMS, INC., AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC.,

Plaintiffs,

v.

JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual,

Defendants.

Plaintiffs Great-West Life & Annuity Insurance Co. ("Great-West"), the Health and Welfare Plan for Employees of Earth Systems, Inc. and Earth Systems, Inc., the Plan Administrator for the Health and Welfare Plan for Employees of Earth Systems, Inc., plead as follows:

1. This action to enforce the terms of the Health and Welfare Plan for Employees of Earth Systems, Inc. (the "Plan") and for equitable relief arises under the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461. Declaratory relief is also sought pursuant to 28 U.S.C. §§ 2201 and 2202. Injunctive relief is requested pursuant to Federal Rule of Civil Procedure 65.

PARTIES

2. Plaintiff Great-West Life & Annuity Insurance Company is the assignee for collection of the Health and

Welfare Plan for Employees of Earth Systems, Inc. (the "Plan") for the purpose of prosecuting all rights and claims for reimbursement.

3. Earth Systems, Inc. is the Plan Administrator of the Plan and, as such, is authorized to bring this action within the meaning of 29 U.S.C. § 1132(a)(2) and (a)(3)(B)(ii).

4. Defendants Janette Knudson and Eric Knudson are citizens and residents of Los Angeles County, California.

JURISDICTION AND VENUE

5. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132 because this action to enforce provisions of the Plan arises under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

6. Pursuant to 29 U.S.C. § 1132(e)(2), venue is proper in this Court because Defendants reside in this district and because the breach of Plan provisions have occurred and are occurring in this district.

FACTUAL ALLEGATIONS

7. Defendant Eric Knudson was an employee of Consultants Southern California, a wholly-owned subsidiary of Earth Systems, Inc. He elected to participate in the Plan for purposes of obtaining medical, surgical, and hospital benefits for himself and for his wife Janette

Knudson, as such, Janette Knudson, is a "covered person" under the Health and Welfare Plan for Employees of Earth Systems, Inc. (the "Plan")

8. On or about June 10, 1992, Janette Knudson was involved in an automobile accident. As a result of the accident, Janette Knudson asserted a claim for personal injuries against Honda Motors of America, Inc., Galpin Motors, Inc. and Hyundai Motor Company.

9. In connection with the same injures [sic] alleged in that claim, the Plan paid medical benefits to the Defendants in the amount of $411,157.11.

10. The Plan maintains an express provision for right of recovery which states:

A third party may be liable or legally responsible for expenses incurred by a covered person for

an illness; or a sickness; or a bodily injury.

When this happens we will, subject to all other terms and provisions of this booklet, pay any benefits which are payable for the expenses incurred by the covered person for the treatment of such illness, sickness or bodily injury. (The loss).

RIGHT OF RECOVERY. We will, at our sole option, have the right to recover from the covered person any payment for benefits paid for treatment of such loss under this booklet which the covered person is entitled to receive from a third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the covered person receives:

The third party;

or the third party's insurer or guarantor;

or the covered person's uninsured motorists insurance.

This lien will not exceed:

the amount of benefits paid under this booklet for the treatment of a loss; or

the amount received by the covered person for such medical treatment from the third party.

CONDITIONS:

The covered person must cooperate fully with us in asserting our right to recover. If the covered person: – makes any recovery as set forth in this provision; and – fails to reimburse us fully for any benefits paid under this provision; then he will be personally liable to us [to] the extent of such recovery up to the amount of the first lien.

before any benefits are paid for the treatment of such loss under this booklet, we may require the covered person to provide all information and sign and return all documents necessary to exercise our rights under this provision.

11. Additionally, Eric Knudson signed, on behalf of Janette Knudson, a Right of Recovery Agreement wherein they agreed in pertinent part that:

I also understand that under the terms of the Plan, the Plan may recover from me any payment for benefits paid under this Plan for which I or my dependents may be entitled to receive from a third party. The Plan shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise, that I or my

> dependents receives from another party, the other party's insurer or guarantor, or my own insurer or guarantor. Said first lien shall be for the amount of medical and hospital benefits paid by the Plan. I shall be personally liable to the Plan to the extent of such recovery up to the amount of its first lien. I agree to cooperate fully with the Plan in asserting its rights to recover.

12. Defendants settled their claims for $650,000.00. Plaintiff have [sic] requested assurance that Defendants will honor the terms of the Plan, but Defendants have failed and refused to provide such assurances.

I. INJUNCTION AGAINST ACTS AND PRACTICES THAT VIOLATE THE TERMS OF THE PLAN

13. Pursuant to 29 U.S.C. § 1132(a)(3), Plaintiffs seek an injunction against Defendants: (1) to prevent the Defendants from violating the terms of the Plan and (2) to enforce the terms of the Plan.

14. By not agreeing to reimburse the Plan the amount recovered, Defendants have violated, and therefore breached the terms of the Plan.

15. Since this act and/or practice violates the Plan's terms, this Court should enter an order enjoining Defendants and all of those persons in active concert or participation with them, from violating the Plan's terms.

16. Specifically, the Court should enjoin Defendants and all those in active concert or participation with them, to reimburse the Plan in the amount of $411,157.11 out of any proceeds they recovered from third parties.

II. DECLARATORY RELIEF

17. Pursuant to 28 U.S.C. §§ 2201, 2202, Plaintiffs request that the Court order and declare that:

A. The terms of the Plan provide for full reimbursement from Plan participants and their beneficiaries for sums paid by the Plan to the participants and/or their beneficiaries which the participant or beneficiary is able to recover from third parties;

B. Defendants are required to reimburse the Plan in the amount of $411,157.11 out of any proceeds Defendants recovered from responsible third parties.

III. TEMPORARY RESTRAINING ORDER

18. Pursuant to Fed. R. Civ. P. 65(b), Plaintiffs are entitled to a temporary restraining order, restraining Defendants from seeking state court approval of their proposed settlement until Plaintiffs' rights have been determined by this Court or from cashing any checks received, or otherwise disposing of any funds received, pursuant to settlement of their claims against Honda, Galpin, and Hyundai, because the attorney for Defendants has represented to counsel for Plaintiffs that he and Defendants will seek to obtain state court approval of their plan to deny the Plaintiffs their right of reimbursement and disburse the tendered funds to Defendants despite Plaintiffs' rights.

19. Plaintiffs will be irreparably harmed if Defendants are allowed to proceed with their plan to obtain state court approval and disburse funds since Plaintiffs

will be unable to collect the Plan's funds except, if at all, after time-consuming and costly litigation. Moreover, Defendants may be able to argue that a finding in the state court regarding the Plan's rights would preclude the Plan from obtaining a determination by this Court.

IV. PRELIMINARY INJUNCTION

20. Pursuant to Fed. R. Civ. P. 65, upon notice and hearing, Plaintiffs are entitled to a preliminary injunction enjoining Defendants from (1) seeking state court approval of their settlement or (2) cashing any checks received, or otherwise disposing of any funds received, pursuant to settlement of their claims against Janette and Eric Knudson, until the rights of Plaintiffs have been determined by this Court.

V. PERMANENT INJUNCTION

21. Defendants have failed to honor Plaintiffs' subrogation rights under the Plan. Accordingly, pursuant to Fed. R. Civ. P. 65, Plaintiffs are entitled to a permanent injunction preventing Defendants from cashing any checks, or otherwise disposing of any funds, received in their claims against Honda, Galpin, and Hyundai, and enjoining Defendants to tender to Plaintiffs $411,152.11, the amount the Plan has paid on behalf of Janette Knudson.

PRAYER FOR RELIEF

22. Plaintiffs request that they have a declaratory judgment, temporary restraining order, preliminary

injunction, and permanent injunction against Defendants preventing Defendants from cashing any checks received, or otherwise disposing of any funds received, pursuant to settlement in their claims and an injunctive order enjoining Defendants to reimburse the Plan in the amount of $411,152.11, including appropriate prejudgment and post-judgment interest and for any other relief to which it is entitled, and that it be awarded its reasonable attorneys' fees and costs.

Dated: July 3, 1997

Respectfully submitted,

FORD & HARRISON LLP

BY: /s/ Linda Claxton
Linda Claxton Johnson
JACKSON, LEWIS, SCHNITZLER & KRUPMAN

By: /s/ Thomas H. Lawrence
Thomas H. Lawrence

VERIFICATION

I, as Chief Financial Officer for the Health and Welfare Plan for Employees of Earth Systems, Inc., verify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to my personal knowledge, information and/or belief.

Dated this 3rd day of July, 1997 at Palo Alto, CA.

/s/ Jerol Brown
Jerol Brown

THIS CONSTITUTES NOTICE
OF ENTRY AS REQUIRED
BY FRCP, RULE 77(d).

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et al., Plaintiffs, v. JANETTE KNUDSON, et al., Defendants.	CV 97-3745 JMI (JGx) **ORDER DENYING PLAINTIFFS' EX PARTE APPLICATION FOR TEMPORARY RESTRAINING ORDER** (Filed Jul. 9, 1997)

IT IS HEREBY ORDERED:

This Court is in receipt of Plaintiffs' *ex parte* Application for a Temporary Restraining Order. This Court is also in receipt of Defendants' Oppositions. After careful review, considering all the arguments and materials presented by the parties, the Application is hereby DENIED.

BACKGROUND

This action arises under the Employee Retirement Income Security Act of 1974 ("E.R.I.S.A."), codified at 29 U.S.C. § 1001, *et seq.* Plaintiff Great-West Life & Annuity Insurance Company ("Great-West") is the assignee for collection of the health and welfare plan for employees of Earth Systems, Inc. ("Earth Systems"). Defendants are

Janette and Eric Knudson, husband and wife. Mr. Knudson was an employee of Earth Systems when he and his wife were involved in an automobile accident which left Mrs. Knudson a quadriplegic for life.

Defendants in 1993 sued Hyundai Motors of America, and others, in Los Angeles Superior Court. Though Plaintiff Great-West was the assignee with rights of subrogation on an E.R.I.S.A. funded policy, it did not until recently seek to intervene in that action. Instead, when the Knudsons and Hyundai agreed on a $650,000.00 settlement, Great-West removed that case to federal court (*Knudson, et al. v. Hyundai Motors of America, Inc., et al.*, CV 97-2801 JMI (ANx)). This Court recently remanded that case because Great-West, a non-party in that action, had no right to remove the case to federal court.

At about the same time, Plaintiffs filed the instant action. They have now applied for a Temporary Restraining Order, asking this Court to enjoin the state court from approving the settlement agreement and enjoining Defendants from receiving any settlement funds. Plaintiff Great-West alleges that it is entitled to $411,157.11 of the settlement proceeds because it paid out that amount in plan benefits to pay for Defendants' medical expenses. Because the E.R.I.S.A. plan provided for first-lien reimbursement of medical expenses recovered from third parties, Plaintiff Great-West argues that it is entitled to injunctive relief.

ANAYLSIS

Interlocutory injunctive relief is appropriate if the moving party can show either: (1) a likelihood of success

on the merits and the possibility of irreparable injury; or (2) that serious questions exist on the merits and the balance of hardships tips sharply in its favor. *Associated Gen. Contractors of Cal. v. Coalition for Economic Equity*, 950 F.2d 1401, 1410 (9th Cir. 1991). Alternatively, a court may issue an injunction if it finds: (1) a strong likelihood of success on the merits; (2) a possibility of irreparable injury to the moving party; (3) that the balance of hardships favors the moving party; and (4) in certain cases, that the public interest favors injunctive relief. *Johnson v. California State Bd. of Accountancy*, 72 F.3d 1427, 1430 (9th Cir. 1995).

In this case, injunctive relief is not appropriate. It is well settled that a federal court may not enjoin a state court proceeding "except as expressly authorized by Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments." 28 U.S.C. § 2283. This rule codifies the general rule of restraint in cases such as this, where an unnecessary injunction against a separate sovereign promises to disrupt the delicate balance of federalism. In this case, Plaintiffs have made no showing that there exists any of the three narrow exceptions mandated by statute. For that reason alone, the Application must fail.

Also, it appears that Plaintiff is not likely to succeed on the merits. The settlement agreement, which promises to provide $650,000.00 to the Knudsons, allocates damages as follows:

Loss of Earnings	5%
Past Medical Expense	5%
Future Medical Expense	45%
Loss of Enjoyment of Life; Distress; Long-Term Disability	40%
Other	5%

Because past medical expenses reflect only five per cent of the proposed settlement amount, it does not appear that Plaintiff Great-West will be entitled to full subrogation. Rather, it appears that Great-West will ultimately recover far less than the amount it seeks here.

Two more reasons support denial of Plaintiffs' Application. Plaintiffs have not alleged irreparable harm, as their rights of subrogation remain intact, leaving them an adequate legal remedy to recover what they are rightly due once the settlement is paid. Further, Great-West has filed this Application after failing for three years to intervene in the state court action. Such a glaring omission raises a strong suspicion that Plaintiffs are forum shopping at the eleventh hour.

CONCLUSION

Accordingly, Plaintiff's Application is hereby DENIED.

IT IS SO ORDERED.

DATED: July 9, 1997

/s/ James M. Ideman
James M. Ideman
United States District Judge

JEFFREY S. POP & ASSOCIATES
Jeffrey S. Pop, Esq. – State Bar #054343
9107 Wilshire Boulevard
Suite 600
Beverly Hills, California 90210
(310) 273-5462 (310) 274-7749 (Fax)

Attorneys for Defendant
JANETTE KNUDSON

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., Plaintiffs v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	)	Case No.: CV 97-3745 JMI (JGx) DEFENDANT JANETTE KNUDSON'S ANSWER TO PLAINTIFFS' FIRST AMENDED VERIFIED COMPLAINT

Defendant Janette Knudson, an Individual, through her attorney of record, Jeffrey S. Pop & Associates, a Law

Corporation by Jeffrey S. Pop, hereby responds to the Verified First Amended Complaint as follows:

1. In response to Paragraph 1 of the Complaint, Defendant Janette Knudson, an individual, upon information and belief, admits that Plaintiffs are bringing this action allegedly under the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 but otherwise denies generally and specifically, each and every other allegation contained in Paragraph 1 of the Complaint.

2. In response to Paragraph 2 of the Complaint, Defendant Janette Knudson lacks sufficient information and belief to admit or deny the allegations contained in Paragraph 2 and therefore denies generally and specifically, each and every allegation contained in Paragraph 2 of the Complaint.

3. In response to Paragraph 3 of the Complaint, Defendant Janette Knudson lacks sufficient information and belief to admit or deny the allegations contained in Paragraph 3 and therefore denies generally and specifically, each and every allegation contained in Paragraph 3 of the Complaint.

4. In response to Paragraph 4 of the Complaint, Defendant Janette Knudson admits that she is a citizen and resident of Los Angeles County but based upon lack of sufficient knowledge and belief, denies, generally and specifically, each and every other allegation contained in Paragraph 4 of the Complaint.

5. In response to Paragraph 5 of the Complaint, Defendant Janette Knudson denies generally and specifically, each and every allegation contained in Paragraph 5 of the Complaint.

6. In response to Paragraph 6 of the Complaint, Defendant Janette Knudson admits that she resides in the central district but denies, generally and specifically, each and every other allegation contained in Paragraph 6 of the Complaint.

7. In response to Paragraph 7 of the Complaint, Defendant Janette Knudson admits that Defendant Eric Knudson was at one time an employee of Earth Systems, Inc. but does not have sufficient knowledge and belief upon which to admit or deny the other allegations as set forth in Paragraph 7 and based upon such information and belief Defendant Janette Knudson, denies, generally and specifically, each and every other allegation contained in Paragraph 7 of the Complaint.

8. In response to Paragraph 8 of the Complaint, Defendant Janette Knudson admits each and every allegation contained in Paragraph 8 of the Complaint.

9. In response to Paragraph 9 of the Complaint, Defendant Janette Knudson does not have sufficient knowledge and belief to admit or deny the amount for medical benefits that were paid for by the Plan. Based upon such lack of information and belief, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 9 of the Complaint.

10. In response to Paragraph 10 of the Complaint, Defendant Janette Knudson does not have sufficient knowledge or belief to admit or deny the allegation set forth in Paragraph 10 of the Complaint and based upon lack of such information, denies generally and specifically, each and every allegation contained in Paragraph 10 of the Complaint.

11. In response to Paragraph 11 of the Complaint, Defendant Janette Knudson does not have sufficient knowledge or belief to admit or deny what documents, if any were signed by Eric Knudson. Based upon such lack of knowledge and belief, Defendant Janette Knudson therefore denies, generally and specifically, each and every allegation contained in Paragraph 11 of the Complaint.

12. In response to Paragraph 12 of the Complaint, Defendant Janette Knudson admits that the gross settlement was approved by the Superior Court after proper notice. A true copy of said order approving settlement and for the establishment of a Special Needs Trust is attached hereto as Exhibit 1 and incorporated by this reference herein. Defendant Janette Knudson denies, generally and specifically, each and every other allegation contained in Paragraph 12 of the Complaint.

13. In response to Paragraph 13 of the Complaint, Defendant Janette Knudson lacks sufficient knowledge and belief to admit or deny and therefore, denies, generally and specifically, each and every allegation contained in Paragraph 13 of the Complaint.

14. In response to Paragraph 14 of the Complaint, Defendant Janette Knudson alleges that she obeyed the

Court Order, a true copy of which is attached hereto as Exhibit 1, including the reimbursement to the Plan through her attorney in the amount of Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70), as ordered by the Court but denies, generally and specifically, each and every other allegation contained in Paragraph 14 of the Complaint.

15. In response to Paragraph 15 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 15 of the Complaint.

16. In response to Paragraph 16 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 16 of the Complaint.

17. In response to Paragraph 17 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 17 of the Complaint.

18. In response to Paragraph 18 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 18 of the Complaint.

19. In response to Paragraph 19 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 19 of the Complaint.

20. In response to Paragraph 20 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 20 of the Complaint.

21. In response to Paragraph 21 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 21 of the Complaint.

22. In response to Paragraph 22 of the Complaint, Defendant Janette Knudson denies, generally and specifically, each and every allegation contained in Paragraph 22 of the Complaint.

AFFIRMATIVE DEFENSES

FOR A FIRST, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

23. Plaintiff Great-West by refusing to intervene in State Court action and/or by failing to file a lien in State Court has waived its right to bring this matter in Federal Court Order in order to appeal the Superior Court Order entered which is attached hereto as Exhibit 1.

FOR A SECOND, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

24. Plaintiff, due to its waiver, is prevented from bringing this action against Defendant Janette Knudson.

FOR A THIRD, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

25. Defendant Janette Knudson, through her attorney, has complied with Court Order attached hereto as Exhibit 1 and a client trust account check in the amount of Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) was sent to Great-West pursuant to the Court Order which settles this matter.

FOR A FOURTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

26. Plaintiff Great-West is collaterally estopped from bringing this action.

FOR A FIFTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

27. Defendant Great-West is barred from bringing this claim under the "Make Whole Rule" which governs this recovery litigation as set forth in *M. Barnes v. Independent Automobile Dealers Assoc. of Calif. Health & Welfare Benefit Plan* 64 F.3d 1389, 1393 (9th Cir. 1995).

FOR A SIXTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

28. Plaintiff Great-West is guilty of unclean hands in its actions herein which provides complete defense to this action.

FOR A SEVENTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

29. Plaintiff Great-West impliedly admits in Paragraph 12 that its Plan's document did not allow for a first recovery of all monies expended and this action explicitly conflicts with the "Make Whole Rule."

FOR AN EIGHTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

30. Plaintiff Great-West did not give any consideration for the alleged signature of Eric Knudson on any documents as alleged in Paragraph 11 and therefore such lack of consideration bars this action.

FOR A NINTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

31. Janette Knudson and Eric Knudson were separated and had irreconcilable differences following the June 10, 1992 tragic accident. Defendant Eric Knudson failed to obtained consent of Janette Knudson and failed

to disclose the alleged existence of the document referred to in Paragraph 11 of this Complaint.

FOR A TENTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

32. Any insurance or ERISA Plan document properly disseminated must be read in its entirety.

FOR A ELEVENTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

33. Upon information and belief, Defendant Janette Knudson alleges that the Complaint has failed to join the employer, an indispensable party and as such must be dismissed.

FOR A TWELFTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

34. Defendant Janette Knudson alleges that Plaintiff Great-West is guilty of fraud with respect to its conduct in attempting to modify the terms and conditions of the ERISA Plan after June 10, 1992.

FOR A THIRTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

35. Plaintiff's claim is barred under the equitable principle of laches in that all proceeds were distributed as ordered by the Superior Court before the service of this case on Defendant Janette Knudson.

FOR A FOURTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

36. Plaintiff failed to notify the State Court or Defendant of its continuing claim after receiving notice of the Motion heard on July 23, 1994 following the Federal Court's remand of the underlying case in Superior Court. Such failures support the equitable principle of waiver, laches and unclean hands as affirmative defenses herein.

FOR A FIFTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE, DEFENDANT ALLEGES:

37. Both Earth Systems and Plaintiff failed to notify Janette Knudson of any ERISA plan document which prevented her from commencing litigation for those allegedly responsible for her injuries or which provided for the first right of complete reimbursement from a settlement of any such litigation prior to June 10, 1992.

FOR A SIXTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

38. Earth Systems failed to properly follow statutory requirements mandated by ERISA with respect to any claim it had or by giving notification to Janette Knudson before and during the time that Janette Knudson was receiving medical treatment that was allegedly paid for by a health plan.

FOR A SEVENTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

39. Defendant Janette Knudson did not receive any extraordinary or different medical benefits for which she gave an independent consideration to Earth Systems and/or Great-West. Such lack of consideration is a complete defense to this action.

FOR A EIGHTEENTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

40. Plaintiffs failed to timely file and serve this action. Defendant Knudson alleges that all acts of performance for which a permanent injunction or a temporary restraining order is requested occurred prior to the service of the Complaint in this case. Plaintiff's own dilatory conduct prevents it from obtaining any injunctive relief as prayed for in this case.

FOR A NINETEENTH, SEPARATE AND AFFIRMATIVE DEFENSE,

DEFENDANT ALLEGES:

41. The acts complained of by Plaintiff have been completed in accordance with a valid order of the Superior Court, a copy of which is marked as Exhibit 1 to this Answer and incorporated by this reference herein.

WHEREFORE, Defendant Janette Knudson prays for judgment as follows:

1. That the Complaint be dismissed in its entirety;

2. That Defendant Janette Knudson recover attorneys fees as permitted by statute;

3. That Defendant Janette Knudson be entitled to recover costs as incurred herein;

4. That Defendant Janette Knudson be entitled to any relief that the Court deems is just and proper herein;

Dated: August 21, 1997

JEFFREY S. POP & ASSOCIATES

By: /s/ Jeffrey S. Pop
Jeffrey S. Pop, Esq.

Attorneys for Defendant
JANETTE KNUDSON

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 97-3745 JMI (JGx)
[Caption Omitted In Printing]

DECLARATION OF JANETTE KNUDSON

I, Janette Knudson, declare:

1. I am Plaintiff in the case entitled *Knudson v. Hyundai Motors Company, et al.*.

2. On June 10, 1992, I became a quadriplegic during a rollover accident involving a 1991 Hyundai Excel at which I was driving.

3. I have given my deposition in this litigation. Since December 19, 1993, I have been represented by attorney Jeffrey S. Pop in the above-captioned litigation.

4. I understand the parameters of the Special Needs Trust. I need the assistance of a Trustee to help manage my financial problems and I have a substantial physical handicap.

5. To the best of my knowledge, I have never signed any documents which provided for liens for health care regarding my injuries. In fact, until January 9, 1997, I was *not* aware that Great West Life and Annuity was asserting any claim against this case.

6. I am aware that Medi-Cal has a lien for the health care coverage they have provided to me. I fully expect and understand that Medi-Cal will be repaid.

7. Unfortunately, after my injury, my husband and I have remained separated and have been living apart. At

no time after June 10, 1992, have we been able to reconcile and live together. I am the custodial parent for our daughter, Jenna Knudson, who has resided with me from the time I was released from the rehabilitation hospital to date for a period over four (4) years.

8. At no time has my estranged husband, Eric Knudson, ever discussed with me the fact that he made any promises to any health care provider or subrogation company regarding my case.

9. Eric Knudson is a Plaintiff in this litigation and has his own counsel, attorney David Lederer.

10. I have reviewed the costs incurred by Jeffrey S. Pop & Associates in preparing my case for trial. I am aware of the testing, time, effort, and numerous experts employed by Jeffrey S. Pop, Esq. as consultants in order to attempt to prove the crash worthiness theory that has been advanced in this litigation. I, along with the Trustee, Louise Curinga, has reviewed the costs incurred as itemized as One Hundred Sixty-One Thousand Seven Hundred Sixty Dollars ($161,760.00). I do not object to these costs.

11. I understand and appreciate that my attorney has reduced his attorney's fees from Forty Percent (40%) to Thirty-Three and One-Third Percent (33⅓%) which in effect in [sic] will allow Forty-Three Thousand Three Hundred Thirty-Four Dollars ($43,334.00) more to be funded into the Janette Knudson Special Needs Trust.

12. I do not understand the claims be[ing] made by Great West Life Annuity Company since my husband paid for health insurance premiums through his former

employer. I never was provided care other than that allowed under the original health insurance policy to my knowledge. I believe that after the first year or so, my husband, Eric Knudson, lost his job at Earth Systems. I believe that through COBRA rights and another insurance company paid for my health care.

13. I understand the rationale for settlement of this case in the gross amount of Six Hundred Fifty Thousand Dollars ($650,000.00). I further understand that if this case proceeded to trial without a satisfactory result that I would receive no compensation for my injuries.

14. This compromise settlement will provide funds for The Janette Knudson Special Needs Trust which may assist the ease of my living for several years.

15. Under these circumstances, I agree to the settlement. I regret that a Special Needs Trust be approved. I request that the Court use fairness and equity in deciding the dispute of Great West. I have no objection to repaying the amount of the Medi-Cal lien as required by law.

I have read this Declaration which consists of Four (4) pages and I declare under penalty of perjury that the foregoing is true and correct. Executed this 24 day of March, 1997 at [Illegible], California.

/s/ J Knudson
Janette Knudson

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 97-3745 JMI (JGx)
[Caption Omitted In Printing]

THE JANETTE KNUDSON SPECIAL NEEDS TRUST

THIS TRUST AGREEMENT is established as of this ___ day of ___, 1997 for the benefit of JANETTE KNUDSON whose date of birth is October 31, 1958 (hereinafter "the beneficiary") pursuant to a court-approved settlement in proceedings titled, for purposes of convenient reference, *Knudson v. Hyundai*, Los Angeles Superior Court No. LC022329. LOUISE CURINGA is the initial trustee of this trust. Unless otherwise specified, the term "trustee" as used herein shall refer to LOUISE CURINGA and any successor trustee. The singular term "trustee" as hereinafter used shall include the plural term "trustees" unless the context indicates otherwise.

ARTICLE I DESCRIPTION OF TRUST CORPUS

The trust corpus shall include any and all amounts designated as payable to the trustee hereunder resulting from the above-referenced litigation which the trustee is expressly authorized to accept and to hold in trust as hereinafter directed. The trustee hereby acknowledges receipt of the assets described in Schedule A attached hereto, which assets together with any other property of the trust shall be held, administered and distributed in trust as hereinafter provided. Except as herein expressly provided, no additions to the trust corpus may be made from any other source.

ARTICLE II REVOCATION AND AMENDMENT

This trust is irrevocable and not subject to amendment by any person.

ARTICLE III DISPOSITION OF TRUST ESTATE

The trust estate shall be held, administered, and distributed for the benefit of JANETTE KNUDSON (sometimes hereafter referred to as "the beneficiary") as follows:

A. *Introduction.* JANETTE KNUDSON suffers from a disability which substantially impairs her ability to provide for her own care and custody and which constitutes a substantial handicap. It is the intent of this instrument that this trust continue in existence as a supplemental (and emergency) fund to public assistance for JANETTE throughout her life unless earlier terminated under the trust's provisions. Currently there exist basic living needs such as special programs and equipment which public benefits may not provide. It is vitally important that JANETTE continue to receive these services in order to maintain a level of human dignity and humane care. If this trust were to be invaded by creditors, subjected to any liens or encumbrances, or cause public benefits to be terminated, it is likely that the trust corpus would be depleted prior to JANETTE's death, especially since the cost of care for disabled persons (not including any emergency needs) is high. In this event, there would be no coverage for emergencies or supplementation for basic needs. The following trust provisions should be interpreted in light of these concerns and this stated intent.

B. *Special Needs.* The trustee shall pay to or apply for the benefit of JANETTE KNUDSON such amounts from the principal or income, up to the whole thereof, as the trustee in the trustee's sole discretion may from time to time deem necessary or advisable for the satisfaction of the beneficiary's special needs, and any income not distributed shall be added to principal. As used in this instrument, "special needs" refers to the requisites for maintaining the beneficiary's good health, safety and welfare when in the discretion of the trustee such requisites are not being provided by any public agency, office or department of any city, county, or state government, or by the federal government or any other public or private agency. "Special needs" shall include, but not be limited to, attendant care and special equipment not available from Medi-Cal or other public resources; transportation; programs of training and treatment; and necessary recreation and entertainment not available from public benefits.

C. *Spendthrift.* No interest in the principal or income of this trust shall be anticipated, assigned or encumbered, or shall be subject to any creditor's claim or to legal process, prior to its actual receipt by the beneficiary. Furthermore, because this trust is to be conserved and maintained for the special needs of JANETTE KNUDSON, no part of the corpus thereof, neither principal nor undistributed income, shall be construed as part of the beneficiary's "estate" or be subject to the claims of voluntary or involuntary creditors for the provision of care and services, including residential care, by any city, county, or state government, or by the federal government or any

other public or private agency except as otherwise provided herein.

D. *Public Benefits.* The trustee is not responsible for seeking support and maintenance for the beneficiary from available public resources. However, in making distributions to or for the beneficiary for her special needs as herein defined, the trustee shall take into consideration the applicable resource and income limitations of the public benefit programs for which the beneficiary is eligible, including Supplemental Security Income (SSI), Medi-Cal, and any other appropriate state or local agency serving the disabled. All references in this instrument to "Medi-Cal" shall include any other state's Medicaid program equivalent.

E. *Supplemental.* No part of the corpus of the trust created herein shall be used to supplant or replace public assistance benefits of any city, county, state, federal or other governmental agency which has a legal responsibility to serve persons with disabilities which are the same or similar to the impairment(s) of the beneficiary herein. For purposes of determining the beneficiary's eligibility for SSI, Medi-Cal, AFDC, In-Home Support Services (IHSS) and rehabilitation service from the State Department of Rehabilitation and any other program of public benefits, no part of the principal or undistributed income of the trustee estate shall be considered as a resource to said beneficiary. In addition, no part of the trust may be used for the recurring needs of AFDC recipients under MPP Section 42-211.256. In the event a trustee is requested to release principal or income of the trust to or on behalf of the beneficiary to pay for equipment, medication, or services which Medi-Cal is authorized to

provide (were it not for the existence of this trust), or in the event a trustee is requested to petition the court or any other administrative agency for the release of trust principal or income for this purpose, the trustee is authorized to deny such request and to take whatever administrative or judicial steps may be necessary to continue the Medi-Cal eligibility of the beneficiary, including obtaining instructions from a court of competent jurisdiction ruling that the trust corpus is not available to the beneficiary for Medi-Cal eligibility purposes. Any expenses of the trustee in this regard, including reasonable attorney's fees, shall be a proper charge to the trust estate.

F. *Trust Termination.* Unless earlier terminated under the provisions of this instrument and subject to the notice and payback provisions of Paragraph I of this Article III, the trust shall cease on the death of JANETTE KNUDSON and the undistributed balance of the trust estate shall be distributed as the beneficiary may direct by the exercise of a special power to appoint the balance of the principal and any undistributed income of the trust estate, or any part thereof, to any one or more persons or entities, or trusts for their benefit, other than the beneficiary's estate, the beneficiary's creditors, or creditors of the beneficiary's estate. Such power of appointment shall be exercised only by a provision in the beneficiary's last Will or Codicil expressly exercising such power. Unless within thirty (30) days after the beneficiary's death the trustee has actual notice of the existence of a Will or Codicil exercising such power (whether or not the document has been filed or admitted to probate), the trustee shall, without incurring any liability to any appointee, proceed as if

such power had not been exercised; however, this sentence shall not bar any right which an appointee may have to enforce the appointment.

Any part of the trust estate with respect to which the beneficiary shall not have exercised the above special power of appointment shall be distributed to the beneficiary's daugther, JENNAFER KNUDSON, if then living, otherwise, to JENNAFER's then-living issue, by right of representation. If JENNAFER is then deceased and leaves no issue then living, the undistributed balance of the trust estate shall be distributed to the heirs at law of JANETTE KNUDSON, their identities and respective shares to be determined in accordance with the laws of the State of California then in effect governing the succession of separate property not acquired from a predeceased spouse.

Any portion of the trust estate distributable to a person who has not attained age twenty-one (21) on the date of distribution shall be distributed to a custodian of the trustee's selection to be held for such person until he or she attains age twenty-one (21) under the California Uniform Transfers to Minors Act.

G. *Backstop*. Notwithstanding anything to the contrary contained in the other provisions of this trust, in the event that the existence of this trust has the effect of rendering the beneficiary ineligible for Supplement Security Income (SSI), Medi-Cal, or any other program of public benefits, or in the event a claim is asserted by a third party, including a public entity, against any trust assets, the trustee may (but is not required) to terminate

this trust, in whole or in part. Prior court approval shall be required for any termination under this provision.

Thereupon, the portion so terminated, subject to the provisions of Paragraph I, shall be distributed, free of trust, to the persons and in the relative shares set forth in the foregoing Paragraph F as if the beneficiary were then deceased and failed to exercise the special power of appointment referred to therein; provided, however, that termination under this paragraph may only occur if the person or persons to whom the trust assets are distributed has attained the age of twenty-one (21).

It is the intent of this instrument that after termination of the trust under the foregoing provision, the distributee shall conserve, manage and distribute the proceeds of the former trust estate for the benefit of JANETTE KNUDSON to ensure that she has sufficient funds for her basic living needs when public benefits are unavailable or insufficient. This request pertaining to the management of the trust proceeds after the termination of the trust is precatory, not mandatory.

In determining whether the existence of the trust has the effect of rendering the beneficiary ineligible for SSI, Medi-Cal, or any other program of public benefits, the trustee is hereby granted full and complete discretion to initiate either administrative or judicial proceedings, or both, for the purpose of determining eligibility and all costs relating thereto, including reasonable attorney's fees, shall be a proper charge to the trust estate.

H. *Expenses*. Upon the death of JANETTE, the trustee may pay any death taxes that may by reason of said beneficiary's death be due regarding the trust assets,

and all expenses of said beneficiary's last illness and funeral, and expenses related to administration and distribution of the trust estate if, in the trustee's discretion, other satisfactory provisions have not been made for the payment of such expenses.

I. *Compliance with Federal and State Law.* It is the intent of this instrument, as confirmed by the Court's approval of this document in *Knudson v. Hyundai*, that this trust shall not be construed as an available resource to the beneficiary by reason of the provisions of Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. § 1396p(d) (4) (A)). In order to comply with the foregoing, the trustee is hereby directed that on the death of the beneficiary or other termination of the trust the trustee shall satisfy from the balance of the trust assets any and all proper state claims for reimbursement for medical assistance paid on behalf of the beneficiary under a State plan up to an amount equal to the total medical assistance paid. In addition, on the death of the beneficiary or other termination of the trust, the trustee shall give such notice as required by California Probate Code Section 3605(c) or successor provision thereto.

J. *Separate Fund.* In the event the trustee accepts public benefits of the beneficiary as a trust asset and agrees to administer such benefits as a part of the trust estate, all such benefits and all earnings of the beneficiary of this trust shall not be commingled with other trust assets but shall be separately held by the trustee.

K. *No Perpetual Trusts.* Unless terminated at an earlier date under the foregoing provision, any trust created under this Agreement shall cease on the date which

is twenty-one (21) years after the decease of the last to survive of the beneficiaries alive or in being at the time of the beneficiary's decease and thereupon the trustee shall distribute and deliver all of the balance of any share of the trust estate or any portion thereof then held for the benefit of a living beneficiary of said trust to such beneficiary or to his or her legal representative.

ARTICLE IV SUCCESSOR TRUSTEE

LOUISE CURINGA shall serve as initial trustee of this trust. If she is unwilling or unable, for any reason, to act or to continue to act as trustee, then WAYNE SMITH shall serve as trustee.

Notwithstanding the foregoing nomination of successor trustees, JANETTE KNUDSON may designate a different order of successor trustees or name different individuals or entities as successor trustees, by an instrument in writing dated and signed by her. Unless the successor trustee named in this instrument has actual notice of the existence of a written nomination separate from this instrument, the nomination of successor trustee contained in this instrument shall be construed as fully effective and the successor trustee nominated herein may proceed as if a separate nomination does not exist. No person who acts in reliance upon any representation made by a successor trustee as to his or her authority to act in such capacity shall incur any liability to the beneficiary, the trustor, or heirs of the beneficiary and trustor for permitting the successor trustee to exercise any powers under this instrument.

Any trustee serving hereunder shall have the power, exercisable at any time and from time to time, to appoint any person or persons, or bank or trust company as an agent or custodian with respect to the trust assets and with respect to any duties herein placed upon the trustee.

Any trustee may at any time resign from any trust hereby established by depositing in the United States mail, postage prepaid, a notice of such resignation addressed to the person or persons then entitled to receive payments hereunder at the addresses of such person or persons last known to the trustee, and such resignation shall take effect at the expiration of sixty (60) days from the date of mailing such notice, and the Affidavit of any officer of a corporate trustee as to the date of mailing such notice shall be conclusive evidence of its mailing.

Upon resignation or the occurrence of a vacancy in the position of trustee for any reason, unless provision is made under this Trust Agreement for the appointment of a successor, the following in the order of prior right hereafter listed shall have the power and preference to designate a successor trustee or trustees to act when no other trustee is designated as successor trustee by this instrument:

1. Beneficiary's Representative.

2. A court of competent jurisdiction under California Probate Code Section 17000 *et seq.*, or successor provisions thereto.

All such designations shall be exercised in writing and shall be effective on delivery to the successor trustee

and the beneficiary of the trust. Any successor trustee, however appointed, shall be responsible only for those trust assets actually received and shall have no duty or obligation to inquire into the acts or omissions of any predecessor trustee.

Except with respect to the power to appoint a successor trustee, all trustees, however appointed, shall have the same power as such original named trustee.

ARTICLE V BOND

A surety bond in an amount set by the Court shall be required of any person serving as trustee hereunder.

ARTICLE VI INCAPACITY DETERMINATION

If any power holder or any trustee serving hereunder shall become incapacitated through illness, age or other cause, such person shall no longer have the power to exercise any rights reserved in this trust as power holder, trustee or otherwise. Incapacity may be determined by the power holder delivering to the trustee or the trustee delivering to any person nominated herein as successor trustee a written instrument declaring from and after such receipt that he or she shall no longer have the power to exercise any rights reserved in this trust; or one (1) physician with at least five (5) years of clinical experience after completion of residency may deliver to the trustee in the event of the incapacity of the power holder or the successor trustee in the event of the incapacity of the trust a certification in writing that said person no longer has the capacity as a result of illness, age or other cause

to exercise any rights reserved in this trust; provided, that if such physician (or successor) described above delivers a certification in the manner directed above stating the power holder or trustee's incapacity has terminated, then the power holder (or trustee) shall be deemed restored to full capacity for purposes of this Agreement. The appointment of a conservator of either the person or the estate, or both, of a power holder or trustee shall be a conclusive determination of incapacity for purposes of this Article.

ARTICLE VII PROVING CHANGE OF TRUSTEE

Whenever a trustee succeeds to office for any reason, such succession shall be evidenced by the written certification of the Beneficiary's Representative that the successor is the duly-acting trustee or co-trustee and all third parties may rely on such certification as evidence of the trustee's succession. Neither successor trustees nor third parties shall have any liability to the trust or any trust beneficiaries for good faith dealings in reliance upon the documentation specified in this Article.

ARTICLE VIII TRUSTEE POWERS

The trustee, in administering the trusts established under this Agreement, shall have full power and authority, with due regard to the fiduciary obligations of a trustee, in such manner and upon such conditions as the trustee may determine:

A. As to any real property subject to the trust, to make agreements concerning, give and take assignments

of lease and assignments of mortgage or the beneficial interest under a deed of trust, bargain for, give and take bills of sale, give and take bonds concerning, borrow against and extend and renew loans, contract for, convey, covenant, grant a deed of trust, demise, exchange, extend and renew any obligation, give evidence of debt, give an estoppel certificate, give and request full and partial releases or satisfactions of mortgage and deeds of trust, grant hypothecate and encumber by deed of trust, or otherwise, hypothecate, indemnify, give or take indentures or mortgages, lend against, lease, let, mortgage, negotiate for and to sign, execute, acknowledge and deliver any grant, quitclaim, joint tenancy, or other deed or note, partition, purchase, receive, receipt, remise, release, sell, sublease, transfer, and make such other instruments in writing of any kind or class as may be necessary and proper in the premises and to collect rents, disburse funds, hire professional property manager, to repair and improve, take and possess any such real property.

B. To purchase and retain, without liability for doing so, assets, whether real or personal, which are exempt for purposes of eligibility for the SSI and Medi-Cal programs, including, but not limited to, a principal residence for use by the trust beneficiary, with or without rent charged to the beneficiary as the trustee shall determine, regardless of whether the particular asset so retained is a kind and quality of which the trustee would ordinarily purchase for trust accounts;

C. To invest, reinvest and, to the extent deemed advisable by the trustee, to keep invested the assets of the

trust estate that persons of prudence, discretion and intelligence acquire for their own account, in stocks (common and preferred, including puts, calls and options, whether for cash, credit or on margin, and including shares in investment companies, investment trusts or mutual funds) bonds, debentures, notes or any other types of securities, interests, assets on property, whether real or personal, or in shares or units of participation in common trust funds, or to participate in making investments with others;

D. To borrow money for the benefit of the trust on such terms and conditions as the trustee may deem proper and, if the trustee shall determine it to be necessary, to encumber the trust property or any part thereof by mortgage, deed of trust, pledge or otherwise, as security therefor;

E. To hold a security in the name of a nominee or in other form without disclosure of the trust so that title to the security may pass by delivery, but the trustee shall be liable for any act of the nominee in connection with the security so held;

F. To appoint and employ such agents and employees as the trustee may deem necessary or advisable, including (without limiting the generality of the foregoing) accountants, attorneys, investment counselors, and custodians of the trust property, and to compensate any person or entity serving as conservator for the beneficiary reasonable amounts for services rendered in this capacity and as reimbursement for reasonable out-of-pocket expenses;

G. To incur and pay all taxes, assessments, costs, charges, fees and other expenses of every kind with respect to the trust which the trustee may deem necessary or advisable in the administration of any trust hereby created, including reasonable fees of the trustee, and to compromise or otherwise adjust claims in favor of or against the trust;

H. To continue to hold the property received into the trust at its inception or subsequently added to it or acquired pursuant to proper authority if and as long as the trustee, in the exercise of good faith and of reasonable prudence, discretion and intelligence, may consider that retention is in the best interests of the trust.

I. To make divisions or distributions of trust property in pro rata or non pro rata divisions or distributions, in cash or in kind or partly in cash and partly in kind, including undivided interests in any property, whenever the trustee shall be required to make divisions or distributions of the trust estate pursuant to the terms hereof, and for this purpose to make such divisions and distributions made in kind or partly in kind at the fair market value of such trust property at the date or dates of such divisions or distributions, without regard to the adjusted basis for income tax purposes of any such property so distributed;

J. To exercise any and all powers now or hereafter conferred on the trustee by law, consistent with the purposes of the trust, or to disclaim any power, authority or discretion conferred upon the trustee by the provisions of this Agreement or by law by filing a written disclaimer with the beneficiary of the trust.

K. The trustee shall be entitled to reasonable compensation for services rendered and for counsel engaged by the trustee, including services in connection with the termination of revocation in whole or in part of any trust hereunder. Such compensation of the trustee and counsel shall be paid wholly from principal or wholly from income or partly from each as the trustee deems proper without prior court order, and the determination of the trustee shall be conclusive.

L. Additional property acceptable to the trustee may be added to any trust hereunder by any persons.

M. Income accrued or unpaid on trust property when received into the trust shall be treated as any other income.

N. Among successive beneficiaries of this trust all taxes and other current expenses shall be prorated over the period to which they relate on a daily basis.

O. Unless the trustee shall have received actual written notice of the occurrence of an event affecting the beneficial interest of any trust hereunder, the trustee shall not be liable to any beneficiary of any such trust for distribution made as though such event had not occurred.

P. If an individual trustee and a corporate trustee are acting, whenever there shall be a dispute, deadlock or difference of opinion between them on a question of joint discretion, a determination of the individual trustee shall be binding upon the corporate trustee, but the corporate trustee shall bear no liability or accountability for any act or transaction entered into as a result of the enforcement

of the individual trustee's privilege if it shall have dissented in writing in advance of such act or transaction.

Q. No trustee shall be liable to any trust beneficiary, or remainderman, or to an heir of the beneficiary for the trustee's acts or failure to act except for willful misconduct or gross negligence. The trustee shall be authorized to charge to the trust estate any attorney's fees and related costs incurred by the trustee in the trustee's defense against any action, cause of action, claim or demand made by anyone for any act or default of the trustee that does not result from the trustee's willful misconduct or gross negligence.

R. No successor trustee shall be liable for any act, omission, or default of a predecessor trustee. Unless requested in writing within sixty (60) days of appointment by an adult beneficiary or remainderman of the trust, no successor trustee shall have any duty to investigate or review any action of a predecessor trustee and may accept the accounting records of the predecessor trustee showing assets on hand without further investigation and without incurring any liability to any person claiming or having an interest in the trust.

ARTICLE IX COURT SUPERVISION

Except as provided in Article X regarding accountings, there shall be no court supervision of this trust, although the provisions of Probate Code Sections 17000 *et seq.*, or other California Probate Code sections then in effect which govern such trusts, shall be applicable to the end that the Superior Court may entertain petitions with

respect to the administration of such trusts as therein provided.

ARTICLE X ACCOUNTINGS

Except as may be requested by an interested person under Probate Code Sections 17000 *et seq.*, or successor provisions thereto, or as may otherwise be required herein, there shall be no Court accountings required of the trustee or any successor trustee of this trust; provided, however, that the co-trustees serving hereunder, or successor trustee, shall prepare and deliver by regular mail, postage prepaid, to the Beneficiary's Representative at the address hereafter set forth (or other address as directed by the Beneficiary's Representative) an annual financial report in the form required by California Probate Code Section 16063, or successor provision thereto, which report shall include:

A. A statement of receipts and disbursements of principal and income that have occurred during the last complete fiscal year of the trust or since the last account;

B. A statement of the assets and liabilities of the trust as of the end of the last complete fiscal year of the trust or as of the end of the period covered by the account;

C. The trustee's compensation for the last complete fiscal year of the trust or since the last account;

D. The agents hired by the trustee, their relationships to the trustee, if any, and their compensation, for the last complete fiscal year of the trust or since the last account;

E. A statement that the recipient of the account may petition the court pursuant to Probate Code Section 17200 to obtain a court review of the account and of the acts of the trustee;

F. A statement that claims against the trustee for breach of trust may not be made after the expiration of three years from the date the beneficiary receives an account or report disclosing facts giving rise to the claim.

Unless the Beneficiary's Representative delivers a written objection to the trustee within thirty (30) days after receipt of an account, it shall be final and conclusive in respect to the transactions disclosed in the account as to all beneficiaries and remaindermen of the trust, including unborn and contingent beneficiaries and remaindermen. Further, after settlement of an account by agreement of the parties objecting to it or by expiration of the thirty (30) day period, the trustees shall no longer be liable to any beneficiary or remainderman of the trust in respect to transactions disclosed in the account, except for the willful misconduct or gross negligence of the trustee.

In the event the Beneficiary's Representative delivers a written objection to the annual report within the thirty (30) day period, the trustee shall submit an accounting to the court for review and approval in the form and pursuant to the procedures set forth in the California Probate Code for conservators.

JEAN OMAN, _____, shall serve as the Beneficiary's Representative. If she is unwilling or unable, for any reason, to act or to continue to act as the Beneficiary's Representative, JANETTE KNUDSON shall

appoint a successor Beneficiary's Representative. If JANETTE KNUDSON is unwilling or unable for any reason to appoint a successor Beneficiary's Representative, the person last serving as Beneficiary's Representative shall appoint a successor Beneficiary's Representative. Upon resignation or the occurrence of a vacancy in the position of Beneficiary's Representative for any reason if the provisions of this instrument fail to result in the designation and appointment of a successor Beneficiary's Representative, a court of competent jurisdiction shall appoint a successor Beneficiary's Representative. All such designations shall be exercised in writing and shall be effective on deliver to the successor Beneficiary's Representative. Any successor Beneficiary's Representative shall have the same power as such original named Beneficiary's Representative.

The Beneficiary's Representative shall be entitled to reasonable compensation for services rendered in this capacity, the amount and frequency of such compensation to be in the sole discretion of the trustee.

In the event that the above provisions fail to result in the appointment of a successor Beneficiary's Representative, then a court of competent jurisdiction shall appoint a successor pursuant to Probate Code Section 17000 *et seq.*, or successor provisions thereto.

ARTICLE XI DISCLAIMER OF TAX-SENSITIVE POWERS

It is the intent of this instrument that no trustee serving hereunder shall possess powers over the trust estate which would cause the trust assets to be included

in such person's taxable estate for federal estate tax purposes. In the event any power held in connection with this trust (which is not disclaimed) has the effect of causing any assets of the trust to be included in such person's estate for federal estate tax purposes, then such person's estate may assert a claim against the trust estate for the amount of any federal estate taxes required to be paid as the result of the power. If such person determines it necessary or advisable, he or she may disclaim any power granted herein by an instrument in writing. In the event of such a disclaimer, the disclaimed power shall terminate.

ARTICLE XII NO DISCHARGE OF OBLIGATIONS

No trustee serving under this Agreement shall make or join in any decision to pay, apply or distribute trust income or principal for the discharge of any of the legal obligations of the trustee, including, but not limited to any obligation of support which the trustee may owe to the beneficiary under the laws of the state where the trustees reside.

ARTICLE XIII LAW PERTAINING TO TRUST

This Agreement shall be administered in the State of California though, in fact, the trustee may reside elsewhere and its validity and construction shall be controlled by the laws of California.

ARTICLE XIV CONTESTS

Should any beneficiary provided for herein, either directly or indirectly, contest or attack this Agreement or any of its provisions, or aid another in so doing, or attempt to provide for the disposition of the trust estate other than as this instrument has provided, then, in that event, any provisions made herein for such contesting beneficiary are hereby revoked and any such portion of the trust estate to which such contesting beneficiary would have been entitled shall be held, applied and distributed as if such contesting beneficiary had predeceased JANETTE KNUDSON without issue. The trustee is hereby authorized to defend, at the expense of the trust estate, any contest or other attack of any nature on this trust or any of its provisions.

ARTICLE XV INTENTIONAL OMISSIONS

Except as otherwise provided in this instrument, it is the intent of this instrument to intentionally and with full knowledge omit to provide herein for any person not named herein.

ARTICLE XVI PAYMENTS TO OTHERS

When any beneficiary entitled to receive payments hereunder is, in the absolute judgment of the trustee, mentally or physically incompetent (irrespective of whether legally so adjudicated), the trustee may in her discretion expend or apply such payments for the benefit of the beneficiary or to the person or persons with whom such beneficiary then resides.

ARTICLE XVII TERMINATION WHERE SMALL

If the value of the assets held in any trust hereunder in the discretion of the trustee becomes sufficiently small that the administration thereof is no longer economically desirable, the cost thereof is disproportionate to the value of the assets, or the continuation thereof is no longer in the best interests of the beneficiary, the trustee may terminate such trust. Upon termination as herein provided, the trustee shall distribute the property of such trust to or on behalf of the beneficiary.

ARTICLE XVIII COPIES OF TRUST

This Agreement may be executed in counterparts, with each duplicate being considered the original document for all purposes. In addition, a photocopy shall be considered the original document, and all persons may rely on the same for all purposes.

ARTICLE XIX SIGNATURE AUTHORITY

Except as to matters vested exclusively in one or the other trustee, when there are co-trustees, the action of all the trustees in office shall be required in order to act in any matter affecting the trust; provided, however, that except as to matters vested exclusively in one or the other trustee, the trustees may agree between or among themselves and may authorize and delegate any one or more of the trustees, either individually or in concert, to exercise the powers provided for in this trust.

ARTICLE XX NAME OF TRUST

The name of the trust established herein shall be THE JANETTE KNUDSON SPECIAL NEEDS TRUST.

IN WITNESS WHEREOF, the undersigned hereby approve and execute this Agreement on the dates hereafter specified.

Dated: 3/24/97 /s/ Louise R. Curinga
LOUISE CURINGA,
Trustee

Dated: _____
Judge of the Superior Court

APPROVAL OF JANETTE KNUDSON

I have read this trust. I understand that if it is approved by the Court, I will lose the right to manage the settlement monies in this case myself. A trustee will hold the money for me. I will not be able to tell the trustee what to do or control the distribution of the money.

Having been so informed, I hereby consent to my settlement money being placed in this Trust and held under the terms of the Trust.

Dated: 3/24/97 /s/ Janette Knudson
JANETTE KNUDSON

JEFFREY S. POP & ASSOCIATES
Jeffrey S. Pop, Esq. – State Bar #054343
9107 Wilshire Boulevard
Suite 600
Beverly Hills, California 90210
(310) 273-5462 ♦ (310) 274-7749 (Fax)

Attorneys for Plaintiff
JANETTTE KNUDSON

**SUPERIOR COURT FOR THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES –
NORTHWEST DISTRICT**

JANETTE KNUDSON, an individual; ERIC KNUDSON; an individual; Plaintiffs, v. HYUNDAI MOTORS OF AMERICA, INC.; A California Corporation; GALPIN MOTORS, INC.; a California Corporation; HYUNDAI MOTOR COMPANY, a Korea corporation; and DOES 2 through 100, Inclusive, Defendants.	Case No. LC022329 ~~[PROPOSED]~~ **ORDER APPROVING SETTLEMENT AND PETITION DIRECTING THE NET MONIES TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE CODE* §** 3111) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDI-CAL AND OTHER DISPUTED CREDITORS DATE: July 23, 1997 TIME: 9:00 a.m. DEPT: Z (Filed July 23, 1997)
LOUISE CURINGA, Petitioner and Trustee of The Janette Knudson Special Needs Trust	

THE HONORABLE MICHAEL FARRELL, Judge of the Superior Court, upon review of the papers including the United States District Court OSC RE: Remand, Order RE: Oral Argument, Order Granting Plaintiffs' Motion to Remand, Order Remanding Action to Los Angeles Superior court and Order Denying Plaintiffs' *Ex Parte* Application for Temporary Restraining Order issued by Honorable James M. Ideman, United States District Judge, and after finding the Notice of the Requirements for the Establishment of the Janette Knudson special Needs Trust have been met and that the Special Needs Trust proposed is authorized pursuant to *Probate Code* § 3604 and upon review of the Petition, Memorandum of Points and Authorities, Declarations of Janette Knudson and Jeffrey S. Pop, Petitioner's attorney, upon review of all papers and exhibits filed herein including the Conditional Release of All Claims as executed on March 14, 1997, and upon all of the evidence submitted and after considering oral arguments or statements made to the Court herein enters the following Order.

WHEREUPON, this Court finds and orders that:

1. The Janette Knudson Special Needs Trust dated March 23, 1997 is hereby approved and shall be established and administered in accordance with its terms and conditions. A true copy of such Trust is attached as Exhibit 1 to the Petition filed originally for the hearing dated April 23, 1997;

2. The Court specifically finds that Janette Knudson has special needs as defined in the *Probate Code* § 3604 *et seq.* and that the disbursement to The Janette Knudson Special Needs Trust as set forth in paragraph four (4)

herein is substantially less than the present value of the future medical expenses of Janette Knudson as established by evidence set forth in Exhibits 3, 4, and 5 attached to the Petition filed herein;

3. The settlement of the underlying case entitled *Knudson v. Hyundai Motor Company* Case number LC022329 is hereby approved and upon the funding of The Special Needs Trust and the additional disbursement ordered herein;

4. The settlement proceeds of the Six Hundred Fifty Thousand Dollars ($650,000.00) shall be distributed within Twenty-One (21) days of this Order as follows:

(1) One check or draft made payable to The Janette Knudson Special Needs Trust: $260,015.88;

(2) Medi-Cal lien: $2,729.42 pursuant to its July 21, 1997 request as set forth in the Supplemental Declaration of Jeffrey S. Pop, Esq.;

(3) Great West Life and Annuity Insurance Company: $13,828.70 based on its claim for reimbursement of its *pro rata* share of past medical expenses by this settlement;

(4) Jeffrey S. Pop & Associates A Law Corporation (reimbursement for costs and attorneys fees): $373,426.00.

5. This settlement is a compromise of a disputed, highly complex product liability claim. Based upon the evidence submitted herein it is uncertain that Plaintiff Knudson would have prevailed on this claim although there is a substantial economic risk for all parties if this matter proceeded to trial.

6. This Court has considered the denial of the Temporary Restraining Order of the United States District Court Judge Ideman in the case styled *Great West v. Janette Knudson, et al.* Case number CV 97-3745 JMI (JGx). The allocation of the net settlement proceeds for Plaintiff's loss, injuries and damages as set forth in the Conditional Release of All Claims in Exhibit 2 attached to the Petition was as follows:

Past Loss of Earnings and Present Value of Future Loss of Earnings:	5%
Past Medical Expense:	5%
Present Value of Future Medical Expense:	45%
Lifetime Housing, Transportation, Modifications and Accessories:	5%
Loss of Enjoyment of Life, Distress, Long Term Disability:	40%
	100%

This allocation is fair and it is approved. In making this finding, this Court has considered the evidence of the present value of future medical expenses and the present value of the future loss of earnings. (Exhibit 3)

The present value of future medical expenses are estimated to be in excess of Two Million Five Hundred Ninety-Three Thousand Nine Hundred Dollars ($2,593,900.00). (Exhibits 3, 4 and 5)

The total loss of earning for Plaintiff Knudson is Eight Hundred Nineteen Thousand Eight Hundred Twenty-Nine Dollars ($819,829.00). (Exhibit 3)

In this regard, Forty-Five Percent (45%) of the net settlement figure (rounded) to satisfy the present value of future medical expenses equals One Hundred Seventeen Thousand Two Hundred Dollars ($117,200.00) which is only 4.1% of the cost of the present value of future medical expenses. The reimbursement percentage allocated to Great West for past medical expenses amounts to approximately 3.3% of the total post expenditure of Great West Life and Annuity Insurance Company. Similarly, the amount allocated to the total loss of earnings is only approximately 1.6% of the total loss allocated for this damage. These relationships demonstrate that Great West has been provided a proper percentage of the settlement for the portion of reimbursement for past medical expenses actually recovered.

The Health Insurance Policy under which the initial medical benefits were paid for Janette Knudson has been reviewed. (Exhibit 11) In this matter, the Court finds that the reimbursement to Great West is limited to the amount of the net settlement received for reimbursement of past medical expenses. The percentage of damages attributable to past medical expenses are fair and proper as established in the Conditional Release of All Claims between the parties. (Exhibit 2)

7. The attorney fees have been reduced from a contractual Forty Percent (40%) contingency to Thirty-Three and One Third Percent (33 1/3%) contingency although considerable discovery, vehicle testing, seat belt testing including the employment of eleven (11) expert witnesses have occurred. The cost advanced was necessary to procure this compromise result for Plaintiff Janette Knudson.

Based upon the evidence presented, the fact that all parties and interested persons were served with the Petition and Motion, the attorney fees and costs as requested in the Petition are hereby approved.

8. The disbursements, as approved in Paragraph 4, shall be paid by Two (2) checks, one made payable to The Janette Knudson Special Needs Trust in the amount of Two Hundred Sixty Thousand Fifteen Dollars and Eighty-Eight Cents ($260,015.88). The second for the remainder in the sum of Three Hundred Eighty-Nine Thousand Nine Hundred Eighty-Four Dollars and Twelve Cents ($389,984.12) made payable to Jeffrey S. Pop & Associates A Law corporation, Client Trust Account. Upon receipt and credit of the funds, the law firm of Jeffrey S. Pop & Associates is hereby ordered to tender a clients trust account checks to DHS/Personal Injury (Medi-Cal) and to Great West Life and Annuity Insurance Company in the amounts as set forth in paragraph 4 above.

9. It is further Ordered that upon receipt of such funds, the Petitioner and through attorney of record shall deliver a Dismissal with Prejudice to Defendant's attorney for filing with this Court.

The foregoing is so Ordered.

Date: JUL 23 1997 MICHAEL J. FARRELL
Judge of the Superior Court

[Proof Of Service Omitted In Printing]

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 97-3745 JMI (JGx)
[Caption Omitted In Printing]

I.

PETITION FOR ORDER

DIRECTING THE NET MONEY TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (PROBATE CODE § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT TO MEDI-CAL AND OTHER DISPUTED CREDITORS

PETITIONER Louise Curinga Trustee of The Janette Knudson Special Needs Trust and Plaintiff Janette Knudson respectfully allege:

1. Petitioner, Louise Curinga, is a long term friend of Plaintiff Janette Knudson and has agreed to be the Trustee of the Janette Knudson's Special Needs Trust, a true copy of which is attached hereto and incorporated herein as Exhibit 1.

2. The Plaintiff is Janette Knudson is a Thirty-Nine (39) year old female born on October 31, 1958. Janette Knudson sustained a catastrophic spinal cord injury on June 10, 1992 when the vehicle she was driving, a 1991 Hyundai Excel, that went off the road and rolled over several times. Janette Knudson was immediately rendered a quadriplegic suffering a C6-C7 spinal cord injury.

3. ***COMPROMISE OF DISPUTED CLAIM*** The proposed settlement is a compromise of a disputed claim.

Plaintiff has alleged design defects with respect to both the roof structure and the seat belt design incorporated in the 1991 Hyundai Excel which Janette Knudson was driving. Defendant Hyundai vigorously denies any such defect. As set forth in the Declaration of Jeffrey S. Pop, attached hereto the incident occurred on June 10, 1992 when Janette Knudson was driving her 1991 Hyundai Excel down Interstate 5. Also riding in the 1991 Hyundai Excel in the front right passenger seat was her husband, Eric, in the rear seats were two (2) adult female friends and in the rear middle in a baby seat was Janette's two (2) year old daughter Jenna. The 1991 Hyundai Excel was southbound on Interstate 5 travelling at approximately Seventy-Five Miles Per Hour (75 MPH). After the vehicle passed by a large tractor trailer, it swayed and drifted to the left. Plaintiff attempted to redirect the 1991 Excel toward the right. She lost control of the vehicle which continued in a centrifical skid across the highway and off into the right shoulder. The 1991 Hyundai Excel travelled approximately one hundred (100) feet in the soft dirt when it began to rollover with the passenger side down first.

The parties dispute whether the vehicle rolled over as few as two (2) times or as many as four (4) times. During the rollover event, the adult female passengers who were in the back of the vehicle were not wearing their seat belts, were ejected. One of the passengers subsequently died. Plaintiff Janette Knudson, the driver, who had properly worn her seat belt, was rendered a quadriplegic.

Plaintiff contends that the side rail of the roof between the "A" and "B" pilar moved inward and downward at the same time that her seat belt allowed slack so that Plaintiff in effect involuntarily dove down on the roof of the vehicle as it was upside down thereby sustaining her spinal cord injury.

Defendant denies these allegations and stresses that the vehicle rolled over four (4) times in a violent manner at a high speed. Defendant further contends that Plaintiff's head may have gone through the left window after it broke and that her head may have contacted the ground rather than the roof.

Defendant contends that credible evidence exists that at the time plaintiff lost control that her husband grabbed the wheel making the vehicle uncontrollable. In the alternative, Defendant states that Plaintiff Janette Knudson over-corrected by turning the steering wheel too much thereby causing loss of control and the centrifical skid.

Plaintiff disputes these factual allegations.

4. ***SETTLEMENT NEGOTIATED*** A Conditional Release of All Claims has been negotiated between the parties. A true copy of which is attached hereto as Exhibit 2. The gross amount payable to The Special Needs Trust Janette Knudson and to her attorney of record Jeffrey S. Pop & Associates, a Law Corporation to cover attorney fees, costs, Medi-Cal liens and any additional funds to found to be owed on legally perfected or compromised claims in the amount of Six Hundred Fifty Thousand Dollars ($650,000.00). This case can settle only if The Janette Knudson's Special Needs Trust is approved by the Court. As set forth herein, Janette's present value costs of

the future medical expenses alone is in excess of Two Million Five Hundred Thousand Dollars ($2,500,000.00). Attached hereto as Exhibit 3 is a Report from Economist, Robert Johnson, estimating the future medical costs of the beneficiary.

5. The rehabilitation care costs report has been prepared by Gerry Aster, R.N., M.S., C.R.C., Rehabilitation Consultant, estimating and projecting the annual cost of medical, in-home services, related services, supplies and equipment for Janette Knudson who will need lifetime care and lifetime attendant assistance. A true and correct copy of this Report is attached hereto as Exhibit 4.

6. Attached hereto is Exhibit 5 and incorporated herein. A Report dated January 18, 1996 by Dr. Thomas L. Hedge discusses the medical examination and condition of Janette Knudson which by its terms qualifies Janette Knudson as having a substantial physical handicap which qualifies her for a Special Needs Trust. A true and correct copy of which is attached hereto as Exhibit 5.

7. Both Dr. Hedge and Gerry Aster, R.N. indicate that Janette Knudson will require ongoing services for the remainder of her life, specialized services including neurologist, orthopedist, occupational and physical therapist, an electric wheelchair, adjustable bed, accessibility devices if/and respatory equipment specialized further orthodox medical and paramedical service as well as attendant care to Plaintiff. It will be necessary for her to have a specially equipped and adapted passenger van for driving. All of these are special needs as defined in the *Probate Code* § 3604(b)(1)(2)(3).

8. ***THE JANETTE KNUDSON'S SPECIAL NEEDS TRUST*** Petitioner is seeking by this Petition to have the settlement amount payable either into an annuity payable in monthly amounts to The Janette Knudson's Special Needs Trust or in a settlement amount directly deposited into the Janette Knudson's Special Needs Trust account under the Court's discretionary authority as set forth in *Probate Code* § 3600 *et seq*. Such procedure requires, among other things, that Notice of the time and place of the hearing of the Petitioner be given to the State Director of Health Services, the State Director of Mental Health and the State Director of Developmental Services[1] *Probate Code* § 3602(f) as well as the Court finding:

1) That Plaintiff has disabilities that substantially impairs her ability to provide for her own care and custody which constitutes the substantial handicap; 2) That Plaintiff is likely to have special needs that will not be met without the Trust; 3) That the money to be paid to the Trust does not exceed the amount that appears reasonably necessary to meet the special needs of Plaintiff; and 4) That all statutory liens in favor of the State Department of Health Service, the State Department of Mental Health, the State Department of Developmental Services have been satisfied pursuant to *Probate Code* § 3604. It is also important that the Court determine the rights, if any,

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[1] Plaintiff and Petitioner has given the statutory Notice of Hearing as set forth in *Probate Code* § 3602(f). The proof of service is attached hereto. The Janette Knudson Special Needs Trust (Exhibit 1) was copied separately for review by these agencies.

regarding private health providers who have not perfected any alleged lien rights and/or the amount disputed owed to those who have perfected their rights.

9. ***THE FUNCTIONING OF THE JANETTE KNUDSON'S SPECIAL NEEDS TRUST*** The Janette Knudson's Special Needs Trust is a form of Trust which is designed to continue Plaintiff's eligibility for Medi-Cal, supplemental Social Security Income (SSI) and other benefits which she is and may be eligible in which are necessary for the treatment of her injuries and the furnishing of proper care.

Under the terms of the Trust, the Trustee is authorized to pay or apply for the Plaintiff's benefit as much of the Trust Estate as the Trustee considers necessary or advisable for Plaintiff special needs. (Exhibit 1)

A "special need" is defined as any requirement for maintaining Plaintiff's good health, safety and welfare when such requisite is not available from any public agency, office or department. The purpose of the Trust is a supplement not a supplant to Medi-Cal and other programs of benefits. This purpose is set forth in the Trust which has been served upon the representative of Medi-Cal through the State Department of Health Services, State Department of Mental Health and the State Department of Developmental Services.

Louise Curinga, the Petitioner's long time friend is names ad [sic] the initial Trustee of the Trust. If she is unable to serve, successors have been also named.

Notwithstanding this designation of a Successor Trustee to Louise Curinga, the Trust Agreement provides

that Janette Knudson would have the power to name different Successor Trustee if she wishes under the terms of Article IV. (Exhibit 1)

The Trustee just submit annual accountings to a "Beneficiary's Representative." If the Beneficiary's Representative fails to object to the accounting within Thirty (30) days after its receipt, it shall be conclusively deemed approved.

If the Beneficiary's Representative objects to the accounting and the objection cannot be resolved informally, then the Trustee must submit the accounting to the Court for Court review and approval.

The purpose of these provisions is to avoid the delay and expense of annual accountings to the Court while building in safeguards to insure that the Trust will be properly managed.

10. ***DISBURSEMENT ON BENEFICIARY'S DEATH*** On Janette Knudson's death, the Trust would terminate at which time the Trustee must notify any and all state agencies which have provided services or benefits to the Beneficiary. Pursuant to *Probate Code* § 3605(c), such agencies may submit claims for reimbursement for any services and equipment provided during the term of the Trust. In addition, the State Department of Health Services is specifically authorized to be reimbursed for any Medi-Cal benefits received by the Plaintiff after establishment of the Trust.

Any assets remaining in the Trust after satisfaction of the claims of public agencies shall be distributed as the Beneficiary may direct in her will. If the Beneficiary fails

to execute a will directing disposition of the balance of the Trust, the Trust assets shall be distributed to Janette Knudson's "heirs at law, Jenna Knudson, the minor, her daughter and then to their identities and respective shares to be determined in accordance with the laws of California then in effect governing the succession of separate property not acquired from a predeceased spouse." This is the language that governs the distribution of the property her persons who die without a will.

A copy of the Trust is attached hereto as Exhibit 1 and is incorporated in its entirety by this reference.

11. ***CRITERIA FOR APPROVAL*** All money payable to the Plaintiff in this matter should be paid to the Janette Knudson Special Needs Trust for the following reasons:

(a) As noted above, the Plaintiff is a C6-C7 quadriplegic who is unable to get dressed, get out of bed or care for herself without daily attendant care.

(b) The Plaintiff is likely to have special needs that will not be met without the Trust. Although Medi-Cal currently pays for a portion of the Plaintiff's medical needs, equipment and supplies, and care, no public agency or other source will provide for her non-medical needs, such as special equipment, assistive devices, physical and occupational therapy, specially adapted motor vehicle, residence and additional attendants. The cost of these services, which is substantial, must be paid by the Trust.

(c) The money to be paid to the Trust does not exceed the amount that appears reasonably necessary to meet the Plaintiff's special needs. In light of the Plaintiff's needs for supplemental

services and equipment, sum of Six Hundred Fifty Thousand Dollars ($650,000.00) less attorney fees and costs and Medi-Cal lien and other liens, if any, as indicated in Paragraph 13 below is very moderate. It is clear that the Trust assets will be fully utilized to pay for Janette Knudson's supplemental needs.

12. ***NOTICE REQUIREMENTS*** The agencies required to receive notice of this Petition are as follows:

Department of Health Services
Special Needs Trusts
P.O. Box 225
Sacramento, CA 95814-0225
(916) 323-0164 (phone)
(916) 322-8778 (fax)
Attention: Georgene Craven
Department of Development Services
1600 Ninth Street, Room 240
Sacramento, CA 95814

Department of Mental Health
1600 Ninth Street, Room 151
Sacramento, CA 95814

13. ***SETTLEMENT AGREEMENT*** The parties have entered into a conditional Settlement Agreement and Release of All Claims, a true copy of which is attached hereto as Exhibit 2 which incorporated by this reference herein. This Conditional Release calls for Defendants to pay a total of Six Hundred Fifty Thousand Dollars ($650,000.00) to Plaintiff and to her attorneys of record for complete release provided that The Special Needs Trust is approved. Under the terms of the conditional release of all claims, the monies are paid for Plaintiff injuries after attorney fees and costs are apportioned as follows:

Past Loss of Earnings and Present Value of Future Loss of Earnings:	5%
Past Medical Expense:	5%
Present Value of Future Medical Expense:	45%
Lifetime Housing, Transportation, Modifications and Accessories:	5%
Loss of Enjoyment of Life, Distress, Long Term Disability:	40%
	100%

In the event that the above apportionment is approved, then the total amount to be funded to The Janette Knudson's Special Needs Trust will be determined after deduction of attorney fees, costs, medical liens and finally the disputed claim of Great West as set forth in Paragraph 14 below.

14. *GREAT WEST ALLEGED CLAIM*

(a) A dispute exists with respect to an asserted claim by Great West Life and Annuity Insurance Company. Great West is asserting a claim under a group health insurance policy which was in effect at the time of Janette Knudson's injury on June 10, 1992. The policy covered Eric Knudson and his dependents.

(b) The Declaration of Jeffrey S. Pop indicates that he recently discovered the terms and condition of the underlying policy. Plaintiff's attorney until recently was unaware of the limiting nature of the policy language as compared to the enormous claim being asserted by Great West. Great West is requesting an amount which is not in

accordance with the terms of its policy. Great West has never obtained a lien signed by Plaintiff Janette Knudson. In addition, Great West did not file a Complaint in Intervention. Great West is not a judgment creditor and it has never filed a lien notice in this litigation.

(c) Great West is attempting to claim a right to first recovery on any monies recovered. This contradicts rights set forth in the Group Medical Insurance Policy that was in effect at the time of the accident. A true and correct copy of the group insurance policy that apparently was in effect is filed separately; however, the relevant pages are attached herewith as Exhibit 6 and incorporated by this reference herein. The relevant portion of that policy on page IV-7 states:

"This lien will not exceed:

- the amount of benefits paid under this Booklet for the treatment of the loss; or
- the amount received by the Covered Person for such medical treatment from the third party."

(Exhibit 6)

(d) In this case, the Conditional Settlement Agreement clearly indicates that the Janette Knudson Special Needs Trust is receiving Five Percent (5%) of the net settlement for past medical expenses. The majority of the monies to be paid by Defendant are properly allocated to avoid the exposure for future medical expenses, future loss of earnings, past loss of earnings, loss of enjoyment of life and of course, long term disability and distress.

The Group Health Policy for right of recover is limited by its terms.

(e) As indicated in the Declaration of Janette Knudson attached hereto and incorporated by this reference herein, Eric Knudson and Janette have been separated since the time of the tragic injury. At no time did Janette Knudson sign any claim of lien or has any attorney who represented Janette Knudson ever signed any claim of lien. No extraordinary and additional services were rendered by any healthcare provider.

(f) The Declaration of Jeffrey S. Pop as well as the Proof of Service attached hereto indicates that Notice is being given to Great West so that all disbursements and a total settlement can be approved at one time in order to dismiss this litigation and have the Special Needs Trust correctly funded in accordance with this Petition. A Supplemental Points and Authorities is being presented to the Court in support of Plaintiff and Petitioner's position herein.

15. In accordance with the finding of the establishment of The Janette Knudson Special Needs Trust, the Trust should be funded in the net amount of Two Hundred Fifty-Six Thousand Seven Hundred Forty-Five Dollars and Thirty Cents ($256,745.30).

The calculation for such funding is as follows:

Gross Settlement Amount:		$650,000.00
Attorney's Fees (Reduced to 33 1/3%):	$216,666.00	
Costs Advanced (Previously Itemized to Trustee and Beneficiary:	$161,760.00	
Total Attorney's Fees & Costs:		($373,426.00)
Settlement After Fees & Costs:		$276,574.00
Medi-Cal Lien Gross (Exhibit 7 – 3/19/97 Letter):	$ 1,106.41	
Reserve Medi-Cal:	$ 3,893.59	
Total Medi-Cal:	$ 5,000.00	
Amount Brought Forward:		$276,574.00
Great West Recovery[2] 5% Allocated to Past Medical Fees & Costs:	$ 13,828.70	

[2] The Great West claim has been asserted by letter but has not been perfected. The total medical expenses according to Great West are Four Hundred Eleven Thousand One Hundred Fifty-Seven Dollars and Eleven Cents ($411,157.11). The policy language limits recovery, if any, in this case. There is an argument, no recovery is permitted since no lien has been filed or signed by the Beneficiary, Janette Knudson. No services were rendered due to any lien or promise of Janette Knudson. The recovery offer by way of compromise has been limited to the Group Policy language under proper interpretation in this case. See accompanying Points and Authorities file concurrently herewith.

Total Medical Re-Payments:	($ 18,826.70)
Net to Amount be Funded [sic] to The Janette Knudson Special Needs Trust:	$256,745.30

WHEREFORE, Petition prays that the Court makes the following findings and orders:

1. That all Notice has been given as required by law;

2. That Plaintiff Janette Knudson has a disability that substantially impairs her ability to provide for her own care and constitutes a substantial handicap;

3. That Plaintiff Janette Knudson is likely to have special needs that will not be met without the Trust;

4. That the money to be paid to the Trust does not exceed the amount that appears reasonably necessary to meet the special needs of Plaintiff Janette Knudson;

5. That the payment of all monies due Plaintiff under the compromise shall be paid to the Louise Curinga in the amount of the Janette Knudson's Special Needs Trust;

6. That all statutory liens in favor of the State Department of Health Services, State Department of Mental Health and State Department of Developmental Services in any county or city in the state shall first be satisfied and they are in the amount not to exceed Five Thousand Dollars ($5,000.00) before any money is paid to the Trust;

7. That the assets of the Trust estate are unavailable to the Beneficiary and shall not constitute a resource for

the Plaintiff Janette Knudson's eligibility for Medi-Cal, Supplemental Security Income (SSI), regional center assistance or any other program of public benefits;

8. That the law offices of Jeffrey S. Pop, A Law Corporation disburse to Medi-Cal, a check in the amount not to exceed Five Thousand Dollars ($5,000.00) to cover its statutory liens and a check in the amount Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) made payable to Great West Life and Annuity Insurance Company to total settlement and compromise of any claims under the medical lien.

9. That attorney fees in the amount of Two Hundred Sixteen Thousand Six Hundred Sixty-Six Dollars ($216,666.00) and costs in the amount of One Hundred Six-One Thousand Seven Hundred Sixty Dollars ($161,760.00) be awarded to Jeffrey S. Pop & Associates, A Law Corporation in accordance with his Contingency Fee Agreement which has been reduced in order to make this settlement possible.

10. The net funds equals to the amount Two Hundred Fifty-Six Thousand Seven Hundred Forty-Five and Thirty Cents ($256,745.30) be paid directly into the Janette Knudson's Special Needs Trust or in the alternative, to an annuity which will pay as its investment sums to the Janette Knudson's Special Needs Trust;

11. That any such other and further orders be issued by the Court as it may deemed just and proper.

II.

CONCLUSION

The foregoing Petition and Compromise of disputed claim allowing for the establishment of The Janette Knudson Special Needs Trust should be approved, this matter settled in order to avoid a Four (4) week jury trial.

Respectfully Submitted.

Dated: 3/24/97 /s/ Louise R. Caringa
/s/ Louise R. Caringa, Petitioner

Dated: 3/24/97 JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION

BY: /s/ Jeffrey S. Pop
Jeffrey S. Pop, Esq.
Attorneys for Plaintiff,
JANETTE KNUDSON

VERIFICATION

I, the undersigned, state:

I am the Petitioner herein. The within Petition is true of my own knowledge, except for matters involving the disputed claims of Great West and for those matters stated on my information and belief, and as to those matters I believe them to be true.

I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 3-24-97 day of _____, 1997, at Chatsworth, California.

/s/ Louise Curinga
Louise Curinga

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 97-3745 JMI (JGx)
[Caption Omitted In Printing]

CONDITIONAL RELEASE OF ALL CLAIMS

In consideration of receipt of Six Hundred Fifty Thousand Dollars ($650,000.00) payable to both the Janette Knudson Special Needs Trust and separately to her attorney of record, Jeffrey S. Pop a Law Corporation Client's Trust Account in a total amount of Six Hundred Fifty Thousand Dollars ($650,000.00) less attorney fees of Thirty-Three and One-Third Percent (33 1/3%) and costs the remainder as apportioned as payment for the specified type of damages and shall be paid to Medi-Cal, other Government services and/or valid and legally perfected lienholders as Ordered by the Court and the remainder to the Janette Knudson's Special Needs Trust.

The Defendants have agreed to pay the above referenced sum of money to settle this disputed and vigorously defended claim. The payment is allocated as partial compensation for Plaintiff due to her catastrophic losses after the deduction of attorney's fees and costs as follows:

Past Loss of Earnings and Present Value of Future Loss of Earnings:	5%
Past Medical Expense:	5%
Present Value of Future Medical Expense:	45%
Lifetime Housing, Transportation, Modifications and Accessories:	5%
Loss of Enjoyment of Life, Distress, Long Term Disability:	40%
	100%

The foregoing settlement and effectiveness of this Release is contingent upon the Court approving the Janette Knudson's Special Needs Trust in order to continue Plaintiff's eligibility for Social Services, Social Security Income (SSI) and all other government benefits currently available to Plaintiff.

Upon approval of the Janette Knudson's Special Needs Trust and the settlement, Janette Knudson being of lawful age, does hereby release, acquit and forever discharge HYUNDAI MOTORS OF AMERICA, INC., A California Corporation; GALPIN MOTORS, INC., A California Corporation; HYUNDAI MOTOR COMPANY, A Korea Corporation and all of their employees, agents, personal representatives, attorneys, successors or predecessors in interest, insurance companies, insurance adjusters, insurance agents and brokers (hereinafter collectively designated as the "Releasees") of and from any and all actions, causes of actions, claims, demands, damages, costs, loss of services, expenses and compensation, on account of, or in any way growing out of, any and all known and unknown personal injuries, property damage and intangible damage resulting or to result from or by reason of the conduct of releases occurring at any time prior hereto, the facts of which, in part, are set forth in that certain lawsuit filed in the Superior Court of the State of California, Los Angeles County, Northwest District, entitled, Janette Knudson, *et al.*, Plaintiff, vs. Hyundai Motor Company, *et al.* and Does 2 through 100, Defendant, Case Number LC022329.

WARNING

1. All persons signing this release must read and understand it in its entirety and truly intend to terminate, irrevocably, all their rights to further pursue or prosecute their causes of action, demands or claims against the described Releasees. In particular, please note:

A. The extensive description of the persons released. Some of the persons released are not parties to the lawsuit or arbitration proceeding to be dismissed, but nevertheless your dismissal of them is required as a necessary part of the settlement evidenced by this release.

B. You are waiving all rights under Section 1542 of the California Civil Code, which provides as follows: "CERTAIN CLAIMS NOT AFFECTED BY GENERAL RELEASE – A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which, if known by him, must have materially affected his settlement with debtor."

2. IN ADDITION TO THE FOREGOING, PLEASE NOTE THE FOLLOWING FURTHER PROVISIONS OF THIS RELEASE AND THE SETTLEMENT IT EVIDENCES:

A. I hereby declare and represent that the injuries or damages are permanent and progressive and that recovery therefrom is uncertain and indefinite and in making this release and agreement it is understood and agreed that I rely wholly upon my own judgment, belief and knowledge of the nature, extent and duration of said injuries, and that I have not been influenced by any extent whatever in making this

release by any representations or statements regarding said injuries, damages or any other matters, made by the persons firms or corporations who are hereby released, or by any person or persons representing them, or by any physicians or surgeons employed by them.

B. I hereby declare and represent that I am effecting this settlement and executing this release after having received full legal advice as to my rights from my attorney.

C. I hereby authorize and direct my attorney of record to forthwith dismiss with prejudice the aforementioned lawsuit or arbitration proceeding as against the Releasees.

D. I declare that the incident, accident, injuries or damages above-described did not arise out of or in the course of my employment and that I received no benefits under any workers' compensation act by reasons of said incident, accident, injuries or damages and am not entitled thereto.

E. It is further understood and agreed that this settlement is the compromise of a doubtful and disputed claim, and that the payment is not to be construed as an admission of liability on the part of said Releasees, by whom liability is expressly denied.

F. This release contains the ENTIRE AGREEMENT between the parties hereto, and the terms of this release are contractual.

G. I agree to reimburse and indemnify all released parties for any amounts not adjudicated by the Court in settlement which any insurance carriers, government entities, hospitals or other persons or organizations may

recover from them in legal and perfected liens for reimbursement for amounts paid to me or on my behalf as a result of this accident by way of contribution, subrogation, indemnity, or otherwise.

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

"IT IS UNLAWFUL TO:

(A) PRESENT OR CAUSE TO BE PRESENTED ANY FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS UNDER A CONTRACT OF INSURANCE.

(B) PREPARE, MAKE, OR SUBSCRIBE ANY WRITING, WITH INTENT TO PRESENT OR USE THE SAME, OR TO ALLOW IT TO BE PRESENTED OR USED IN SUPPORT OF ANY SUCH CLAIM. EVERY PERSON WHO VIOLATES ANY PROVISION OF THIS SECTION IS PUNISHABLE BY IMPRISONMENT IN THE STATE PRISON NOT EXCEEDING THREE YEARS, OR BY FINE NOT EXCEEDING ONE THOUSAND DOLLARS, OR BY BOTH."

THE UNDERSIGNED HAS READ THE FOREGOING RELEASE AND FULLY UNDERSTANDS IT.

Signed, sealed and delivered this 14th day of March, 1997, at [Illegible] California.

/s/ Janette Knudson
JANETTE KNUDSON

The foregoing signature of Janette Knudson has been witnessed by Jeffrey S. Pop, Attorney at Law, who has

explained the effect of this Condition Release of All Claims. The foregoing was signed in my presence.

DATED: 3/14/97

/s/ Jeffrey S. Pop
JEFFREY S. POP, ESQ.

Thomas L. Henderson, TN Bar No. 11526
Thomas H. Lawrence, TN Bar No. 17105
McKNIGHT HUDSON LEWIS/FORD & HARRISON LLP
6750 Poplar Ave., Suite 301
P.O. Box 171375
Memphis, Tennessee 38183
(901) 756-1550

Linda Claxton Johnson, CA State Bar No. 125729
FORD & HARRISON LLP
333 South Grand Avenue
Suite 3680
Los Angeles, California 90071
(213) 680-3410

Attorneys for Great-West Life
and Annuity Insurance Company.

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Plaintiffs, v. HYUNDAI MOTORS OF AMERICA, INC.; A California Corporation; GALPIN MOTORS, INC.; a California Corporation; HYUNDAI MOTOR COMPANY, a Korean Corporation; and DOES 2 through 100, inclusive, Defendants.	) CIVIL ACTION) NO.: 97-2801JMI)) **NOTICE OF REMOVAL**

Defendant, Great-West Life & Annuity Insurance Co. ("Great-West"), hereby removes this action to this Court pursuant to 28 U.S.C. § 1441(a) and (c), and in support thereof, states as follows:

1. On March 28, 1997, Great-West was served with copies of a Notice of Motion and Motion, Memorandum in Support, and Proposed Order styled *Janette Knudson, et al. v. Hyundai Motors of America, Inc., et al.*, No. LC022329 in the Superior Court of California for the County of Los Angeles – Northwest District. A copy of the foregoing documents is attached hereto as Exhibit A and constitutes all pleadings, process and other documents served upon Defendant Great-West in this action. These documents were the initial pleadings served upon Defendant Great-West setting forth the claim upon which such action or procedure is based.

2. This action is removable pursuant to 28 U.S.C. §§ 1331 and 1441. Plaintiff asserts claims which raise substantial questions of federal law and which arise out of federal law. Plaintiff asserts a claim for a determination that the Health and Welfare Plan for Employees of Earth Systems, Inc. (the "Plan") is not entitled to enforce the subrogation provisions of its self-funded employee benefit plan against the monies Plaintiff is about to receive in settlement of her state court lawsuit. Plaintiff's claims relate to benefits she received under the Plan, an employee benefit plan as defined and described in 29 U.S.C. § 1002(1) and 1003(a). Plaintiff received benefits under the Plan totaling $411,157.00.

3. Great-West is a Colorado corporation and is the assignee for collection of the Plan for the purpose of

prosecuting all rights and claims for reimbursement or subrogation.

4. Plaintiff's claims further relate to the employee benefit plan within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, and are preempted and superseded by 29 U.S.C. § 1144(a).

5. This action is removable pursuant to the complete preemption doctrine without regard to the well-pleaded complaint rule. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

6. This Court has original jurisdiction of ERISA actions under 29 U.S.C. § 1132(e). This action is founded on claims or rights arising under the laws of the United States in that it is based upon and requires the application of ERISA, 29 U.S.C. § 1144(a). Removal jurisdiction exists under 28 U.S.C. § 1441(b) and (c). *Fravel v. Stankus*, 936 F. Supp. 474 (N.D. Ill. 1996).

7. Plaintiff's claim against Great-West is separate and distinct from the Plaintiff's claims against the other co-defendants. Therefore, this entire action is removable pursuant to 28 U.S.C. § 1441(c).

8. Because removal is proper under 28 U.S.C. § 1441(c), not all defendants are required to join in this notice of removal. *Fravel v. Stankus*, 936 F. Supp. 474 (N.D. Ill. 1996).

9. This notice of removal was timely filed pursuant to 28 U.S.C. § 1446(b) having been filed within 30 days after service of Exhibit A.

10. Venue is proper in this Court.

11. Pursuant to 28 U.S.C. § 1446(d), Great-West will promptly give written notice of the removal of this action to all parties and file a copy of this notice with the state court.

WHEREFORE, Great-West removes this action to this Court.

DATED: April 21, 1997

Respectfully submitted,

FORD & HARRISON LLP

By: /s/ Linda Claxton Johnson
Linda Claxton Johnson

McKNIGHT HUDSON LEWIS/
FORD & HARRISON LLP

By: /s/ Thomas L. Henderson
Thomas L. Henderson

By: /s/ Thomas H. Lawrence
Thomas H. Lawrence

THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d).

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

JANETTE KNUDSON, et al., Plaintiffs, v. HYUNDAI MOTORS OF AMERICA, INC., et al., Defendants.	CV-97-2801-JMI (ANx) **ORDER GRANTING PLAINTIFFS' MOTION TO REMAND** **ORDER REMANDING ACTION TO LOS ANGELES SUPERIOR COURT** (Filed Jun. 30, 1997)

IT IS HEREBY ORDERED:

Plaintiffs Janette Knudson, et al.'s Motion to Remand came before this Court for review on June 2, 1997. After careful consideration and review, the Court hereby GRANTS Plaintiffs' motion.

BACKGROUND

Plaintiff, Janette Knudson, was involved in an automobile accident while driving a car manufactured by Hyundai Motors of America, Inc. Plaintiffs filed suit against Hyundai Motors of America, et al., in the Superior Court of the State of California of the County of Los Angeles. *See Janette Knudson, et al. v. Hyundai Motors of America, Inc., et al.*; Case No. LC022329. The dispute

between Plaintiffs and Hyundai was to be settled by way of the establishment of a trust fund for Plaintiff.

Great-West Life and Annuity Insurance Company ("Great-West") is the assignee of the health insurance company that initially paid Plaintiff's medical expenses following the accident. Great-West, claiming to be a defendant, removed Plaintiffs' case against Hyundai, et al., to federal court before the trust fund could be approved by the state court. Now, Plaintiffs request that the case be remanded back to state court.

DISCUSSION

I. Section 1441 Procedure

Except as otherwise expressly provided by Act of Congress, any civil action brought in a state court of which the district courts of the United States have original jurisdiction, may be removed by the defendant to the district court of the United States for the district and division embracing the place where such action is pending. 28 U.S.C. § 1441. *Accordingly, only a defendant has the power to remove a case to federal court.*

II. Great-West Does Not Qualify as a Defendant Under 28 U.S.C. § 1441

Great-West is a party-in-interest in the instant case to the extent that it hopes to receive compensation from the trust fund for the medical payments it made following Plaintiff's accident. Great-West, however, was never included as a party in *Knudson v. Hyundai*, and it is in no position to qualify itself as a defendant. Not Plaintiffs,

nor any other party in this matter, have made any claims against Great-West. It is Great-West that has a complaint against Plaintiffs. In fact, Great-West has already filed a separate complaint in this court seeking compensation from Plaintiffs. *See Great-West Life & Annuity Ins. Co. v. Janette Knudson, et al.*; CV 97-3745 JMI (JGx).

Plaintiffs have filed a Motion for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors. In the motion, Plaintiffs ask the state court to approve the settlement reached with Hyundai. The proposed settlement includes a provision providing compensation to the parties for past medical expenses. Great-West, however, does not qualify as an adversarial party in the motion. Great-West is only a party-in-interest to the extent that it is to receive compensation from the trust fund as part of the provision providing compensation to parties for past medical expenses. The state court is to decide whether or not the settlement is fair to the parties involved. If the state court finds that the proposed settlement is not fair to Great-West, it will not approve the settlement. Great-West is not in a position to itself oppose Plaintiffs' motion for approval.

III. Great-West Does Not Qualify as a Defendant Under *Fravel v. Stankus*

Great-West claims that it qualifies as a defendant under the holding in *Fravel v. Stankus*, 936 F. Supp 474 (N.D. Ill. 1996), a case from the Northern District of Illinois. In *Fravel*, the injured plaintiff filed a Motion to Adjudicate Lien against a subrogee of a health plan that had made medical payments on behalf of the plaintiff. *Id.*

at 476. The motion was made in connection with a settlement the plaintiff reached with the defendant in the case. The court held that the health plan subrogee qualified as a defendant in the plaintiff's state case because "the action [was] clearly adversarial in nature." *Id.* at 480 (citation omitted).

The holding in *Fravel*, however, does not apply to the instant case. Plaintiffs never filed a Motion to Adjudicate Lien against Great-West. In fact, Plaintiffs dispute Great-West's contention that a lien ever existed. *See* Plaintiffs' Motion, p. 4.

IV. Great-West has Filed a Separate Complaint Against Plaintiff

Plaintiff's Motion to Remand is strengthened by the fact that Great-West has already filed a separate ERISA related complaint against Plaintiffs in federal court seeking compensation for the payments it made relating to Plaintiff's accident. *See Great-West Life & Annuity Ins. Co. v. Janette Knudson, et al.*; CV 97-3745 JMI (JGx). It would be improper to allow Great-West to file a separate complaint against Plaintiffs for compensation and at the same time qualify itself as an adverse party in Plaintiffs' case against Hyundai. Such an outcome would not be in the interests of justice, as Great-West would be seeking compensation for the same expense from two separate sources. By filing a separate federal complaint, Great-West has mooted its argument for removing Plaintiffs' case against Hyundai.

IT IS SO ORDERED.

DATED: June 27, 1997

/s/ James M. Ideman
JAMES M. IDEMAN
United States District Judge

[Proof Of Service Omitted In Printing]

Thomas H. Lawrence, TN Bar No. 17105
OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.
SunTrust Center, Suite 800
424 Church Street
Nashville, TN 75201-7812
(615) 254-1900

Linda Claxton Johnson, CA Bar No. 125729
FORD & HARRISON LLP
333 South Grand Avenue
Suite 3680
Los Angeles, CA 90071
(213) 680-3410

Attorneys for Plaintiffs
Great-West Life & Annuity Insurance Company, The Health and Welfare Plan for Employees of Earth Systems, Inc., and and Earth Systems, Inc., the Plan Administrator for the Health and Welfare Plan for Employees of Earth Systems, Inc.

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. Plaintiffs,	Case No. CV-97-3745 JMI (Jgx) DECLARATION OF JEROL J. BROWN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND FOR PRELIMINARY INJUNCTION

v. JANETTE KNUDSON, and individual; ERIC KNUDSON, an individual, Defendants.	Date: December 29, 1997 Time: 10:00 a.m. Place: Courtroom of the Hon. James M. Ideman (Filed Dec. 8, 1997)

DECLARATION OF JEROL J. BROWN

I, Jerol Brown, declare as follows:

1. I am the Secretary-Treasurer of Earth Systems, Inc. and served as a member of the Board of Trustees of the Earth Systems, Inc. Employee Benefit Trust from 1988 through 1993.[1] The Board of Trustees was designated as the Plan Administrator for the Earth Systems, Inc. Employee Benefit Trust ("The Plan"). I have been employed by Earth Systems since June 1, 1985. My responsibilities as a member of the Board of Trustees included but were not limited to the design, implementation, administration, accounting, and interpretation of health benefits for Earth Systems employees and their dependents. I am familiar with the Plan's policies, procedures and records pertaining to health benefits available to participants of the Plan. I was, as a member of the Plan Administrator, a fiduciary of the Plan based upon being named by the Plan. I exercised discretion in control and management of the Plan. I have personal knowledge

[1] Effective January 1, 1993, Earth Systems, Inc. terminated its employee welfare benefit plan and commenced providing coverage for its employees directly through insurance.

of the facts set forth herein, and if called as a witness in this matter, I could and would testify thereto under oath.

2. Earth Systems, Inc. and its subsidiaries are engaged in commerce or an activity affecting commerce. Earth Systems established and maintained the Plan for the purpose of providing its participants and their dependents, among other benefits, medical, surgical, and hospital care benefits. The Plan was neither a governmental, church or unfunded excess benefit plan. The Plan was not maintained solely for complying with applicable workers' compensation laws or unemployment or disability insurance laws, and was not maintained outside the United States. The Plan was designed to, and did comply with, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq. ("ERISA"). The Plan is an ERISA Plan.

3. Earth Systems self-funded its Plan and was self-funded in providing medical benefits. Earth Systems, at all times relevant, engaged Great-West Life & Annuity Insurance Company ("Great-West") to act as a non-discretionary claims service administrator for the Plan. Great-West's function was, in part, to process claims submitted by Plan participants or their dependents in accordance with the terms of the Plan.

4. Janette Knudson became a participant in the Plan on October 31, 1990 through enrollment as a dependent spouse.

5. The Plan was noncontributory for employee participants and their dependents of the Plan.

5. The Plan was noncontributory for employee participants and their dependents of the Plan.

6. Participation in the Plan was voluntary.

7. Earth Systems, at all times relevant, was responsible for remitting all fees, premiums, and claim payments to Great-West.

8. Earth Systems was required to perform certain functions with respect to the Plan. Earth Systems generally endorsed the Plan, and in addition, performed the following tasks:

(a) determined the design and amendments to the Plan, and decided the coverage and levels of coverage that employees and their dependents were entitled to receive (e.g., Earth Systems determined the size of deductibles and what benefits would be provided with a range of benefits to be paid by Great-West on behalf of the Plan);

(b) provided an accurate accounting of its Plan participants to Great-West for the purpose of determining participation levels and eligibility of its employees under the Plan;

(c) enrolled its employees in the Plan;

(d) distributed the Plan's "Summary Plan Description" (the "SPD") describing Plan benefits to its employees and their dependents upon enrollment in the Plan;

(e) provided the employee claim forms (proof of loss) that the employee filled out and returned to Great-West for claim processing; and

(f) certified eligibility of participants.

9. The Plan document contains an express "Provision for Right of Recovery" (the "Provision"). The Provision entitles the Plan to recover sums that are available from a third party, or third party insurer. The Plan expected by inclusion of the Provision contained within the SPD that the Plan will be reimbursed to the extent of benefits paid, or an amount agreed upon, when a participant makes a recovery from a third party, or third party insurer. The Plan vested the Board of Trustees with the discretion to interpret the Plan, and the Board delegated this responsibility to me in my capacity as a member of the Board of Trustees. A true and correct copy of the express "Provision for Right of Recovery" and the section of the Plan vesting me with discretion to interpret the Plan is attached as Exhibit A hereto.

10. I have interpreted the Plan regarding its right to recover the amount of benefits paid by the Plan on behalf of Janette Knudson. The Plan is entitled to recover 100% of the $411,157.11 paid by the Plan on behalf of Janette Knudson out of the $650,000.00 that she has recovered in her state court action. I have made this determination for several reasons. First, after Ms. Knudson suffered her injuries and while she was incapacitated, her husband, Eric Knudson, executed and returned under cover letter of Janette Knudson's attorney a "right of recovery agreement" wherein he agreed, on her behalf, to reimburse the Plan up to the amount of benefits paid if his wife made a

third-party recovery. A true and correct copy of the "right of recovery agreement" is attached as Exhibit B hereto. Second, and in any event, the terms of the Plan state that the Plan "will have a first lien upon any recovery . . . that the Covered Person receives from . . . the third party" and the lien will not exceed "the amount of benefits paid. . . . " Thus, under the Provision, the Plan is entitled to recover to the extent of benefits paid. Also, since the Plan states that it has a "first lien" on the recovery, the Plan is entitled to recover fully and in first order of priority of payment whether or not Janette Knudson is made whole. Finally, since the Plan states that it is entitled to a "first lien" up to the amount of benefits paid, and since the Plan does not provide that it will pay a portion of Janette Knudson's legal fees and costs, the Plan's recovery should not be reduced to pay a pro-rata share of Janette Knudson's attorney's fees and costs.

11. The provisions discussed above establish that the first sentence of the Right of Recovery provision – ("We will, at our sole option, have the right to recover from the Covered Person any payment for benefits paid for treatment of such Loss under this Booklet which the Covered Person is entitled to receive from the third party.") – does not mean that the Plan's recovery can be limited by an allocation by a covered person's attorney in a settlement agreement of a small amount of settlement funds to past medical expenses, which represents only a fraction of the benefits paid by the Plan. Instead, this sentence introduces the concept that if benefits are paid, and a covered person may be able to seek recovery for the Loss that caused benefits to be paid, but the Plan will be entitled to recover the full amount of benefits paid to the

Covered Person. The remaining portions of the Provision explain the extent of the recovery right. Any other interpretation of this sentence would render the rest of the Provision meaningless.

12. I have determined that the Plan should always receive 100% reimbursement to the extent of benefits paid so that the Plan retains maximum control over efforts to recover from third parties. Additionally, the overall goal in requiring full reimbursement is to provide the greatest amount of benefits to all covered persons under the Plan at the least cost and to protect plan assets.

13. Earth Systems delegated to Great-West the duty to perform certain non-discretionary services for the Plan. The services include benefit determination in accord with the terms of the Plan's SPD, benefit payments in accord with the Plan's SPD, and direct payment of benefits to Plan participants or their assigns. I have interpreted the services provided by Great-West to include notification and enforcement of the Plan's subrogation and/or rights of recovery.

14. The Plan maintained a Stop-Loss Policy to protect the Plan from catastrophic loss. Earth Systems was the designated contract holder and recipient of sums payable through stop-loss.

I declare under penalty of perjury of the laws of the United States that the forgoing is true and correct.

Dated: 8/20/97 /s/ Jerol J. Brown
Jerol J. Brown

Thomas H. Lawrence, TN Bar No. 17105
Lewis, Fisher, Henderson & Claxton
5050 Poplar Ave. Suite 1717
Memphis, Tennessee, 38157
(901) 767-6160

Linda Claxton, CA Bar No. 125729
12100 Wilshire Boulevard, Suite 600
Los Angeles, California 90025
(310) 820-3150

Attorneys for Plaintiffs
Great-West Life & Annuity Insurance Company, the Health and Welfare Plan for Employees of Earth Systems, Inc., and Earth Systems, Inc., the Plan Administrator for the Health and Welfare Plan for Employees of Earth Systems, Inc.

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. Plaintiffs, v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	Case No. CV-97-3745 JMI (Jgx) **SUPPLEMENTAL DECLARATION OF JEROL J. BROWN** Date: March 23, 1998 Time: 10:00 a.m. Place: Courtroom of the Hon. James Ideman

SUPPLEMENT DECLARATION OF JEROL J. BROWN

I, Jerol J. Brown, declare as follows:

1. I, at all relevant times, have been a Trustee of the Earth Systems, Inc. Employee Benefits Trust (the "Trust"), which was created pursuant to the Trust Agreement. A true and correct copy of the Trust Agreement is attached hereto as Exhibit 1. I make this declaration in support of the Plaintiffs' motion for summary judgment and in opposition to Defendants' motion for summary judgment. I have personal knowledge of the matters stated herein and could testify competently thereto if called upon to do so in a court of law.

2. I, as Trustee, with the consent and agreement of the other trustees, delegated to Earth Systems, Inc. the authority to act on behalf of the Trust (to the extent Earth Systems, Inc. did not already possess that authority as the plan sponsor and a fiduciary of the Plan) and to, among other activities, contract on behalf of the Trust and the Plan for such administrative services and insurance, including stop loss policies, as might be required to operate the Trust and the medical plan and to retain a third party administrator to assist in operating the Plan. Accordingly, it has been at all times my intention and understanding as Trustee that Earth Systems, Inc. is a duly authorized legal representative of the Trust, with the power to enter into the agreements with Great-West Life & Annuity Insurance Company ("Great-West"). The Minutes of the Board of Directors Meeting held on September 8, 1989 establish that the Trustees of the Trust at that time (myself, Carl Greenlee, and Albert Gribaldo), along with the Board of Directors of Earth Systems, Inc., agreed that

Earth Systems, Inc. should enter into an Administrative Services Only agreement with Great-West. True and correct copies of those minutes are attached hereto as Exhibit 2. The other activities performed by Earth Systems, Inc., with the approval of the Trustees, are set forth in ¶ 8 of my initial Declaration.

3. I was authorized pursuant to the Trust Agreement to interpret the Earth Systems Inc. Summary Plan Description, which I did for this case on August 20, 1997 when I executed my initial Declaration. The Declaration incorrectly identifies the Flexible Benefits Plan as the document that vests me with the discretion to interpret the Plan. In fact, the Trust Agreement provides me with that discretion. I determined that it was necessary to interpret the Right of Recovery Provision in the Plan to ensure that Earth Systems, and thus the Trust, recovered the maximum amount it was entitled to recover. In that way, the participants and beneficiaries would receive the maximum amount of benefits at the least cost.

4. In my initial declaration, I stated that the Plan was entitled to recover 100% of the $411,157.11 of benefits paid on behalf of Janette Knudson out of the $650,000 she recovered in her state court action. Knudson's attorney questioned me about this in my deposition and asked why his scheme to allocate only $13,828.70 to past medical expenses did not defeat the Plan's claim to full reimbursement. He directed me to a portion of the Summary Plan Description that states that first lien would not exceed the amount of medical treatment received by the covered person and asked me how that affected my interpretation.

5. I first explained that the Plan has a first lien right of recovery to the extent of benefits paid and, thus, the first dollars recovered are to be allocated to the Plan's first lien regardless of how a covered person and the party she sues choose to allocate the recovery. Thus, the first dollars recovered are presumed to be for medical expenses.

6. The provision Knudson's attorney referred to – that the lien will not exceed the amount received by the covered person for such medical treatment from the third party – applies in situations where the covered person recovers less than the amount of the benefits paid. In that situation, the lien would be limited to the amount of the total recovery. I then provided an example of why I interpreted it the way I did: I want to sell my house to another person (the buyer) for $550,000. The bank has a first lien on the house of $400,000. What I might do is try to make an agreement with the buyer to sell him my house for $500,000 instead of $550,000. I then tell him that if he will allocate only $50,000 of his money to my first lien, then I will sell him my backyard garden hose for $450,000. I then take the $50,000 to the bank and apply $50,000 to pay off my first lien, even though the first lien is $400,000. I'll take the remaining money and apply that to the garden hose, which has no lien on it, and I have made out "scott free". I save $350,000, the buyer saves $50,000 but the bank – the first lienholder – gets fleeced. This would not be allowed.

7. Attached as Exhibit 3 are true and correct copies of the portions of minutes of several Board of Directors meetings pertaining to medical benefits for employees. These minutes show the types of escalating medical costs

that Earth Systems has experienced over the past decade and the measures taken to control those costs. The increasing costs and number of claims between 1988 and the present have caused Earth Systems, Inc. to scale back benefit levels, raise deductibles, and begin requiring employee contributions. Enforcing the Right of Recovery provision in this case will provide a benefit to all participants and beneficiaries because it will allow them to obtain the most benefits at the least cost and may prevent further reductions in benefit levels or increases in deductibles or employee contributions.

8. I have reviewed Janette Knudson's Memorandum of Points and Authorities in Support of Her Cross Motion for Summary Judgment. In that memorandum, Knudson contends that any recovery in this case will not benefit the Plan but only Earth Systems, Inc. That is incorrect. Earth Systems, Inc. is obligated to pay some of the $411,157.11 back to Great-West pursuant to the stop-loss contract with Great-West. The remainder of the money will be paid into the Earth Systems Employee Benefits Trust, which will be reactivated when and if a recovery is obtained. That money will be distributed pursuant to the terms of the Trust, for the benefit of all of the participants and beneficiaries in Earth Systems' employee benefit plan.

9. Since 1981, Earth Systems, Inc. has had in place a "plan" for providing medical benefits to employees of its subsidiaries. The Plan has been funded and insured in different ways over the years, and the terms, level of benefits and the name given to the Plan have occasionally changed. However, the same Plan entity has operated and remained in place continuously to the current date,

including the years from 1991 to 1993 relevant to this action.

I declare under penalty of perjury of the laws of the United States that the foregoing is true and correct.

Executed on 3/6/98 /s/ J J Brown
Jerol Brown

TRUST AGREEMENT

THIS TRUST AGREEMENT is made between EARTH SYSTEMS, INC., having its principal place of business at 1900 Embarcadero Road, Suite 207, Palo Alto, California ("Systems"), and Albert Gribaldo, Carl W. Greenlee and Alvin Rathbun (the "Trustees").

RECITALS

A. Systems has adopted and established the Earth Systems, Inc., Employee Benefits Plan (the "Plan"), effective as of the 1st day of January, 1981.

B. The Board of Directors of Systems has appointed a Board of Trustees (the "Trustees") to administer the Plan in accordance with its terms, and the Trustees have entered into an Agreement with a third-party Service Organization (the "Contract Administrator") to handle claims and other administration for benefits under the Plan.

C. The Plan provides that contributions made by Systems and its Employees ("Participants") shall be held in Trust, invested and thereafter paid out to Participants and their dependents and beneficiaries in order to accomplish the purposes of the Plan.

D. Systems desires to create a Trust associated with the Plan which is intended to qualify as a Tax-Exempt Trust of a Voluntary Employees' Beneficiary Association within the meaning of Section 501(c)(9) of the Internal Revenue Code, as amended, and the Regulations issued thereunder and as a Tax-Exempt Trust under the provisions of the Revenue and Taxation Code of the State of

California. Such Trust is also intended to comply with the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The sole purpose of the Association and the Trust is to provide such life, medical, dental, disability, sickness, accident and other benefits as are set forth in the Plan, as may hereafter be amended, to those Employees of Systems who are eligible to participate in the Plan and to their eligible dependents.

NOW, THEREFORE, Systems hereby establishes the Trust Agreement under the Plan, as hereinafter set forth, and the Trustees agree to hold any and all monies which have been or may be paid to them as Trustees hereunder from time to time IN TRUST for the uses and purposes and upon the terms and conditions hereinafter stated.

ARTICLE I

CONTRIBUTIONS

1.1 *Amount*: Systems shall contribute to the Trust, from time to time, such amounts as are equal to the total contributions by Participants plus such additional amounts as may be necessary to fund payment of claims by Participants and to pay the administrative costs of the Plan and the Trust. All such payments, all investments made therewith and proceeds therefrom, less any disbursements which shall, from time to time, be made by the Trustees, are referred to herein as the "Fund." The Trustees shall hold, manage, and administer the Fund as a single Trust pursuant to the terms of the Plan and this Agreement without distinction between the principal and income.

ARTICLE II

TRANSFER FROM TRUST

2.1 *Payments by the Trustees*: The Trustees shall, in addition to their investment accounts, open and maintain one or more checking accounts in a commercial branch of a national or state bank. The Trustees shall, from time to time, transfer monies from the investment assets of the Trust to the checking account(s) for the purposes of paying benefits under the Plan and administrative expenses of the Plan and Trust. The Trustees shall make distributions of monies from such account(s) to such persons, in such manner, at such times and in such amounts as they shall determine.

In addition to or in lieu of establishing the aforementioned checking accounts, the Trustees may, from time to time, transfer monies from the assets of the Trust, by wire transfer or otherwise, to the Contract Administrator or its order, to cover drafts in payment of claims by Participants, issued by the Contract Administrator.

2.2 *Taxes*: The trustees are authorized to pay from the Trust assets all real and personal property taxes, income taxes and other taxes of any kind levied or assessed under the existing or future laws against the Trust assets. The Trustees shall not be personally liable for any such taxes.

2.3 *Alienation*: The benefits, proceeds, payments or claims of any Participant or Dependent payable from the Trust assets shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary. Any attempt to

anticipate, alienate, sell, transfer, assign, pledge, encumber, garnish, levy or otherwise dispose of or execute upon any right or benefit payable hereunder shall be void. The Trust assets shall not, in any manner, be liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant entitled to benefits hereunder and such benefits shall not be considered an asset of the Participant in the event of his insolvency or bankruptcy.

2.4 *No Diversion of Assets*: No part of the Trust assets shall inure the benefit of any private shareholder or individual other than through payment of benefits under the Plan.

ARTICLE III

ACTIONS OF TRUSTEES

3.1 *Named Fiduciary*: The Trustees appointed by the Board of Directors of Systems to administer the Plan shall be the Plan Administrator as defined in Section 3(16)(A) of ERISA and the fiduciary with the rights, powers, duties, responsibilities, discretion and immunities set forth in the Plan.

3.2 *Trustees Sole Responsibility*: The Trustees shall have sole responsibility for the exercise of their rights and duties as set forth in the Plan, specifically including the determination of the existence, nonexistence, nature and amount of rights and interests of all persons in the Trust and the authority to direct the investment, management and control of Trust assets and to appoint Investment Managers to so direct the Trustees in the investment, management, and control of Trust assets.

3.3 *Maintenance of Records*: The Trustees shall have the sole duty and responsibility to maintain any individual Participant records and to prepare and file all reports and other information required by any federal or state law or regulation relating to the Trust and the Trust assets, or delegate responsibility therefore, except for such reports or information returns as are required by law to be prepared and filed by the Trustees.

3.4 *Designation of Agents*: The Trustees shall, in their sole discretion, have the right to appoint such agents as they may deem necessary to carry out their duties pursuant to the provisions of the Plan and this Trust.

3.5 *Miscellaneous*: Notwithstanding any other provisions contained in this Agreement, the parties hereto specifically authorize and direct any member of the Board of Trustees to sign and execute Internal Revenue Service Form 1024 or any similar form, on behalf of this Trust for the purpose of applying for an initial ruling or determination by the Internal Revenue Service that this Trust is exempt from taxation under Section 501(c)(9) of the Internal Revenue Code.

ARTICLE IV

THE TRUSTEE

4.1 *Acceptance*: The Trustees hereby accept this Trust and agree to perform their duties hereunder. They shall receive Systems' and Participants' contributions and shall hold such contributions in the Trust Fund, together will [sic] all income therefrom and all additions thereto, in trust, pursuant to the terms hereof and for the exclusive benefit of the Participants and their beneficiaries.

ARTICLE V

INVESTMENT OF TRUST ASSETS

5.1 *Fiduciary Responsibilities:* The Trustees shall be the sole fiduciaries with respect to the investment, management and control of the Trust assets contributed by Systems and/or Participants with full discretion in the exercise of such investment, management and control. The appointment, selection and retention of any Investment Manager shall be solely the responsibility of the Trustees. The Trustees are authorized and entitled to rely upon the fact that said Investment Manager is at all times a qualified Investment Manager, as defined in Section 3(38) of ERISA, until such time as the Trustees receive a written notice from Systems to the contrary.

5.2 *Duty of Care*: The fiduciaries of this Trust, whether the Trustees or the Investment Manager, responsible for the investment, management and control of Trust assets, shall discharge such responsibility solely in the interest of the Participants and beneficiaries of the Plan for the exclusive purpose of providing benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and by diversifying the investments of the Plan so as to minimize the risk of large losses, unless, under the circumstances, it is clearly prudent not to do so and in accordance with the documents and instruments governing the Plan and this Trust, insofar as such documents

and instruments, are consistent with the provisions of this Trust.

5.3 *Liability of Fiduciaries*: The parties hereto agree that each of the fiduciaries under the Plan and Trust shall be solely responsible for its acts or omissions. Except as to the extent imposed by the provisions of ERISA, as amended from time to time, no fiduciary shall have the duty or right to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by ERISA, as the same may be amended from time to time, or by any regulations or rulings thereunder. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the Plan and this Trust Agreement unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy said breach or, through his negligence in performing his own specific fiduciary responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

ARTICLE VI

TRUSTEES' GENERAL POWERS

The Trustees shall have the following general powers, in addition to any powers and authorities set forth elsewhere herein, and in addition to and not in limitation of the powers granted and confirmed by law, all of which shall be exercised in the Trustees' fiduciary capacity, as Trustees:

(a) To hold, manage, invest and reinvest the principal and income of the Trust Fund pursuant to the then applicable provisions of this Trust Agreement, without distinction between principal and income, and in any property, real or personal, regardless of where situated, which may be an allowable investment under the provisions of this Agreement.

(b) To hold, manage, invest and reinvest the principal and income of the Trust Fund, in any portions, without distinction between principal and income, and in any property, real or personal, regardless of where situated, including without limitation stocks, common or preferred, bonds, notes, debentures, shares or interests in investment trusts, securities, mortgages, other evidences of indebtedness or ownership in real property, improved or unimproved (all at times hereinafter referred to individually and collectively as "property").

(c) To accept and hold property in the form in which received, in cash or uninvested.

(d) To purchase or otherwise acquire and hold property at any time and upon any terms and conditions.

(e) To sell or otherwise dispose of property at any time and upon any terms and conditions.

(f) To exercise options, rights and privileges to acquire or convert property into similar or other property, to make such acquisitions or conversions, and to accept, hold or dispose of such property.

(g) To hold, manage, operate, improve, mortgage, or lease, and to collect, receive and receipt for rents, issues, profits and other income from property.

(h) To carry insurance on property, with mutual insurers or otherwise, against all risks, for any amount, and upon any terms.

(i) To vote in person or by proxy, or to refrain from voting shares of stock, securities or voting rights in other property.

(j) To join in, dissent from, or oppose any dissolution, liquidation, merger, consolidation, reorganization, recapitalization, readjustment or sale of assets of any such property.

(k) To borrow money for any periods and upon any terms, conditions and security, and to mortgage, pledge, or hypothecate such property as may be required to secure such loans.

(1) To deal with claims, controversies, demands or obligations for or against the Trust Fund, and to enter into any agreements, compromises, settlements, or other dispositions thereof.

(m) To execute, acknowledge, and deliver any instruments and documents in any form.

(n) To use income, proceeds of the disposition of property, or other receipts of any kind for any purpose not inconsistent with the provisions of the Trust Fund

(o) To employ and compensate administrators, agents, accountants, legal counsel (who may be the same as for the Trustor) and other assistants and advisors.

(p) To hold and retain the principal and income of the Trust Fund undivided until actual division shall

become necessary in order to make payment or distribution.

(q) To exercise any rights of election or other rights which may be available to the Trustees.

(r) To classify and allocate receipts of income or corpus, or of disbursements as charges against income or corpus.

(s) To do all acts, to take proceedings and exercise all rights and privileges, although not specifically mentioned herein, as may be necessary to carry out the provisions of the Trust Fund.

(t) To continue to act pursuant to the terms and conditions of this Agreement until actual final distribution of the principal and income of the Trust Fund.

(u) To purchase out of the funds of the Trust Fund, a Group Insurance Policy or Policies from an insurer or insurers of the Trustees' selection, which policy or policies shall provide eligible Plan Participants with such Group Insurance as the Trustees may determine.

(v) To enter into a contract with an insurer to provide indemnification of the Trust Fund in the event of loss, on account of benefits payable to eligible Plan Participants, which is in excess of a maximum loss as determined, from time to time, by the Trustees.

(w) To enter into a contract with an insurance, service or administrative organization, which contract shall provide for the manner in which such organization is to receive, review, process and pay benefits to, or on behalf of, eligible Plan Participants in accordance with any plan to be funded hereunder. If the Trustees shall enter into a

contract with any insurance, service or administrative organization for the purpose of administration of any plan of benefits established by the Trustees hereunder, the Trustees are specifically authorized and empowered to agree to indemnify and hold harmless such insurance, service or administrative organization from any premium taxes or similar gross receipts taxes, related interest, fines or penalties and reasonable expenses incurred in any legal effort to avoid such taxes, interests, fines or penalties which arise out of or in the course of the performance of the administrative functions delegated to such organization by the Trustees.

(x) To exercise all right or privileges granted to a policyholder by the provisions of each policy or allowed by the insurance carrier of such policy, and may agree with such insurance carrier to any alteration, modification, or amendment of such policy, and may take any action respecting such policy or the insurance provided thereunder, which may be necessary or advisable, and such insurance carrier shall not be required to inquire into the authority of the Trustees with regard to any dealings in connection with such policy.

(y) To cancel any policy or policies of insurance which the Trustees have caused to be issued and may purchase in lieu thereof other like insurance from a carrier or carriers, as provided in Paragraphs (u), (v), and (w) above.

(z) All of the foregoing powers and authority of the Trustees may be exercised by them as often as they, in their sole and absolute discretion, may deem advisable without application to or approval by any court.

(aa) In addition to the foregoing, and to all of the specific powers and authorities granted in other places herein, the Trustees shall have such powers and authorities which, in their sole discretion, are reasonably necessary to carry out the intent and purposes of this Trust and the Plan, as either may be amended from time to time.

ARTICLE VII

ACCOUNTS OF THE TRUSTEES

7.1 *Records*: The Trustees shall maintain accurate records and accounts of all transactions hereunder, which shall be available at all reasonable times for inspection or audit by any Plan Participant or any person or persons designated by Systems.

7.2 *Reports*: Within ninety (90) days following (a) the close of each fiscal year of the Trust (which shall correspond to the Plan year) or (b) the effective date of the removal or resignation of the Trustees, the Trustees shall file with Systems a written account setting forth all transactions affected by them subsequent to the end of the period covered by their last previous annual accounting, and listing the assets of the Trust, showing carry and market values of such assets, at the close of the period covered by such account. If Systems so directs, the Trustees shall also submit to Systems such interim valuations, reports or other information as Systems may reasonably require.

ARTICLE VIII

TERMS, RESIGNATION AND REMOVAL OF TRUSTEE(S)

8.1: The Trustees named in this Trust Agreement agree to serve in such capacity until they shall voluntarily resign or shall be removed by Systems. Upon the resignation or removal of any Trustee, Systems shall appoint a replacement Trustee who shall serve in such capacity until his resignation or removal. Replacement Trustees shall be appointed by Systems no later than thirty (30) days following the effective resignation or removal of a Trustee as provided hereunder.

8.2: A Trustee may resign at any time by delivering to the remaining Trustees a written notice of resignation, to take effect no less than sixty (60) days after delivery thereof, unless such time shall be waived by the unanimous consent of the remaining Trustees.

A Trustee may be removed by unanimous request of the remaining Trustees by written notice of removal to take effect no less than sixty (60) days from delivery thereof, unless such time should be waived by the removed Trustee.

Upon removal or resignation, all future liability of such Trustee shall terminate, with the exception that such Trustee shall continue to have the obligation to execute, acknowledge and deliver all documents necessary to transfer and convey all right, title and interest in the Trust assets, together with the Trustee's rights and privileges, to any Successor Trustee, and to account for its tenure as Trustee.

ARTICLE IX

RIGHT TO AMEND

Systems reserves the right, for itself and its successors, to amend the Plan and Trust in whole or in part at any time by resolution of its Board of Directors or that of any such successors by delivering a certified copy of any such Board of Directors' resolution to that effect to the Trustees.

ARTICLE X

AMENDMENT AND TERMINATION

Any amendment shall be stated in an instrument in writing executed by Systems or the Trustees, as the case may be, and this Trust Agreement shall be amended in the manner and at the time therein set forth, and Systems and the Trustees shall be bound thereby; provided, however:

(a) No amendment shall be effective which shall attempt to cause any of the assets of the Trust to be used for or diverted to purposes other than for the exclusive benefit of Participants or their dependents or beneficiaries except that such changes, if any, as may be required to permit the Trust to meet the applicable requirements of the Internal Revenue Code, as now in effect or hereafter amended, may be made;

(b) No amendment shall have any retroactive effect so as to deprive any Participant of any benefit already vested, except that such changes, if any, as may be required to permit the Trust to meet the applicable

requirements of the Internal Revenue Code, as now in effect or hereafter amended, may be made;

(c) No amendment shall create or effect any discrimination in favor of Participants who are officers, shareholders or highly compensated employees; and,

(d) No amendment shall increase the duties or liabilities of the Trustees without its written consent.

ARTICLE XI

SUCCESSION AND ADOPTION

In the event of a liquidation, dissolution, merger, consolidation, reorganization or transfer of Systems, or its property to a successor continuing and carrying on the Trustor's business, any such successor, with the written consent of the Trustees, may adopt this Trust Agreement and be substituted for Systems hereunder by delivering a certified copy of the resolution of its Board of Directors to that effect to the Trustees.

ARTICLE XII

TERMINATION OF PLAN

13.1 *Employer*: Systems has established the Plan and Trust with the intention and expectation of maintaining it indefinitely but Systems may, at any time, for business, financial or other good causes, terminate the Plan and Trust by delivering a certified copy of a resolution to that effect to the Trustees. This Plan and Trust shall also terminate in the event Systems is legally adjudicated a bankrupt, makes a general assignment for the benefit of

creditors, or is liquidated and dissolved, or transfers its business or its property without any successor hereto.

13.2 *Distribution Upon Termination*: Upon the termination of the Trust as herein provided, any and all monies remaining in the Plan after the payment of all expenses shall be used for the continuance of one or more benefits of the type provided by the Plan, until such monies have been exhausted.

ARTICLE XIII

APPLICABLE LAW

The Plan and Trust Agreement shall be construed, administered and governed in all respects under applicable Federal Law, and to the extent that Federal Law is inapplicable, by the laws of the State of California.

ARTICLE XIV

ACTIONS BY SYSTEMS

All actions of Systems taken pursuant to the provisions of this Trust Agreement shall be evidenced by a certified copy of an appropriate resolution of the Board of Directors of Systems which shall be delivered to the Trustees.

IN WITNESS WHEREOF, Systems and the Trustees have caused this Agreement to be executed, by their respective duly authorized officers, as of this 1st day of December, 1980.

EARTH SYSTEMS, INC.

By: /s/ Albert Gribaldo, President
Albert Gribaldo

By: /s/ Alvin Rathbun,
Alvin Rathbun
Vice-President, Secretary-Treasurer

("Systems")

/s/ Alvin Rathbun
Alvin Rathbun, Chairman

/s/ Albert Gribaldo
Albert Gribaldo

/s/ Carl W. Greenlee
Carl W. Greenlee

("Trustees")

Linda Claxton, Esq. (Bar No. 125729)
LEWIS FISHER HENDERSON & CLAXTON, LLP
333 South Grand Avenue, Suite 3680
Los Angeles, California 90071
(213) 680-3410

Thomas H. Lawrence, Esq. (TN Bar No. 017105)
LEWIS FISHER HENDERSON & CLAXTON, LLP
5050 Poplar Avenue, Suite 1717
Memphis, Tennessee 38157
(901) 767-6160

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS INC., THE PLAN FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., Plaintiffs, v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	Case No. CV 97-3745 JMI (JGx) SECOND SUPPLEMENTAL DECLARATION OF JEROL J. BROWN (Filed Mar. 16, 1988) Date: March 23, 1998 Time: 10:00 a.m. Ctrm: Hon. James M. Ideman

I, Jerol J. Brown, declare as follows:

1. I, at all relevant times, have been a Trustee of the Earth Systems, Inc. Employee Benefits Trust (the "Trust"), which was created pursuant to the Trust Agreement. I have personal knowledge of the matters stated herein and could testify competently thereto if called upon to do so in a court of law.

2. The only plan documents that the Health and Welfare Plan for Employees of Earth Systems (as it was called from 1989 – 1993) (the "Plan") was operated under during the times that benefits were paid on behalf of Janette Knudson, were the Earth Systems, Inc. Summary Plan Description (endorsed originally by ESI and the Trustees in 1989 and again in 1991) and the Trust Agreement entered into in 1981. I was responsible for, among other things, managing the financial administration of the Plan at all times relevant hereto. I handled the finances of the Plan by estimating the cost of benefits for the participants and beneficiaries in each of the Earth Systems, Inc. ("ESI") subsidiaries. I would then require each subsidiary to pay the monthly share of that cost into the Trust. I would then use the funds in the Trust to fund benefits that Great-West initially paid as our claims service administrator. If and when our stop-loss attachment points were reached, and Great-West returned money to ESI under the stop-loss contract, I deposited those funds directly into the Trust account. True and correct copies of worksheets, checks, explanation sheets, and deposit slips that evidence much of this process are attached as exhibits to my deposition and are attached as Exhibit 27 to Knudson's Appendix of Exhibits. None of the funds paid to ESI by Great-West were retained by ESI. In fact,

because of the increasing costs of the Plan, ESI was many times required to supplement the funds in the Trust to meet all of the Plan's obligations.

3. The level of benefits provided to participants and beneficiaries decreased after 1993, when ESI terminated its agreement with Great-West because of spiraling costs and began funding its Plan through insurance.

I declare under penalty of perjury of the laws of the United States that the foregoing is true and correct.

Executed on 3/16/98 /s/ J.J. Brown
Jerol Brown

PROOF OF SERVICE

STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 12100 Wilshire Boulevard, Suite 600, Los Angeles, California 90025. On **March 16, 1988**, I served the foregoing document described as: **SECOND SUPPLEMENTAL DECLARATION OF JEROL J. BROWN**

___ by placing___ the original _X_ a true copy thereof enclosed in a sealed envelope addressed as follows:

Jeffrey S. Pop, Esq.
Jeffrey S. Pop & Associates
9107 Wilshire Boulevard, Ste. 600
Beverly Hills, California 90210

___ **BY EXPRESS MAIL**

___ ___ I deposited such envelope in the mail at Los Angeles, California. The envelope was mailed with postage thereon fully prepaid.

___ As follows: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under the practice it would be deposited with the U.S. postal service on that same day with postage thereon fully prepaid at Los Angeles, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit.
Executed on **March 16, 1998**, at Los Angeles, California.

___ ___ **BY PERSONAL SERVICE** I delivered such envelope by hand to the offices of the addressee.
Executed on **March 16, 1998**, at Los Angeles, California.

XX ___ **FEDERAL** I declare that I am employed in the office of a member of the bar of this Court at whose direction the service was made.

LINDA CLAXTON /s/ Linda Claxton
Signature

JEFFREY S. POP & ASSOCIATES
Jeffrey S. Pop, Esq. – State Bar #054343
9107 Wilshire Boulevard
Suite 600
Beverly Hills, California 90210
(310) 273-5462 ♦ (310) 274-7749 (Fax)

Attorneys for Defendant
JANETTE KNUDSON

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., AND EARTH SYSTEMS INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC., Plaintiffs, v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual, Defendants.	Case No.: CV 97-3745 JMI (JGx) **DEFENDANT JANETTE KNUDSON'S STATEMENT OF UNCONTROVERTED FACTS AND CONCLUSIONS OF LAW IN SUPPORT OF THE CROSS-MOTION FOR SUMMARY JUDGMENT; DECLARATIONS OF JEFFREY S. POP AND JANETTE KNUDSON ATTACHED HERETO** Date: February 23, 1998 Time: None Set Ctrm: 5 (Judge James M. Ideman) (Filed May 18, 1998)

All exhibits refer to exhibits in the Appendix, which is filed concurrently herewith, except for reference to declarations or depositions, which may be lodged separately. Documents are not numbered in logical sequence since the Stop Loss Contract was overlooked during Plaintiff's response to defendants' demand for documents and was produced after the deposition of Fry and during the deposition of Tuccitto. The Trust Agreement also was not produced until January 22, 1998, the second day of the deposition of Jerol Brown. It is marked as Exhibit 39.

UNCONTROVERTED FACTS	**EVIDENCE**
1. Earth Systems, Inc., executed and created a Trust Agreement, dated December 1, 1980, which acknowledges that Earth Systems Inc. had adopted and established the "Earth Systems Inc. Employee Benefits Plan ("The Plan"), effective January 1, 1981.	Exhibit 39, Trust Agreement, dated December 1, 1980, Recital "A"; Batestamp No. 809; Brown Depo. 170:22-171:7.
♦ ♦ ♦	
3. The Trust Agreement executed December 1, 1980 between the Trustees and Earth Systems, Inc., appoints a Board of Trustees to administer the "Earth Systems, Inc.	Exhibit 39, Trust Agreement dated December 1, 1980, Recital "B" Batestamp No. 809; Brown Depo. 170:22-171:7.

Employee Benefits Plan" which was effective as of January 1, 1981.

4. The Trust Agreement in Recitals Section C, states that "The Plan provides that contributions made by Systems and its employees ("Participants") shall be held in Trust, invested, and thereafter paid out to participants and their dependents and beneficiaries in order to accomplish the purposes of the Plan."

Exhibit 39, Trust Agreement dated December 1, 1980, Recital "C", Batestamp No. 809; Brown Depo. 170:22-171:7.

5. The Trust Agreement states a portion of in Section D, "The sole purpose of the association and the trust is to provide such life, medical, dental, disability, sickness, accident and other benefits as set forth in the plan, as may hereinafter be amended, to those employees of Earth Systems who are eligible to participate in the plan and to their eligible dependents."

Exhibit 39, Trust Agreement dated December 1, 1980, Recital "D"; Batestamp No. 809; Brown Depo. 173:12-174:10.

6. Plaintiff Great-West Life & Annuity Assurance Company (hereinafter

Exhibit 6, Services Agreement, Batestamp Nos.

referred to as "Plaintiff Great-West") entered an agreement for services with Earth Systems, Inc. and the Plan Administrator, effective January 1, 1990.

213-218; Tuccitto Depo. 30:17-31:20.

7. Under the Service Agreement, in Article IV, it was expressly agreed that "under no circumstances shall Great-West be designated as plan administrator or a fiduciary of the Plan. Nothing herein shall be deemed to constitute Great-West a party to the Plan or to confer any authority or control respecting management of the Plan, authority or responsibility in connection with administration of the Plan."

Exhibit 6, Article IV, Authority in Control and Management of Plan, Batestamp No. 215; Tuccitto Depo. 34:5-35:10.

8. The Service Agreement provided that no event shall an incorrect determination of any benefit be the responsibility of Great-West.

Exhibit 6, Services Agreement, Article V, Indemnification and Limitation of Liability, Batestamp No. 215; Tuccitto Depo. 35:22-36:1.

9. Plaintiff Great-West sold Earth Systems, Inc. a "Stop-Loss Contract" for insurance, dated February 27, 1990, effective January 1, 1990.

Exhibit 17, Stop-Loss Contract, Batestamp Nos. 267-275; Tuccitto Depo. 73:1-6.

10. The only parties to the Stop-Loss Contract were Earth Systems, Inc., "the contract holder" and Great-West Life and Annuity Insurance Company, "the insurer."	Exhibit 17, Stop-Loss Contract, Batestamp No. 267-275; Tuccitto Depo. 72:1-73:26; Brown Depo. 108:16-22.
11. The Stop-Loss Contract sold by Great-West to Earth Systems, Inc. provided for both a specific stop-loss benefit and for an aggregate stop-loss benefit.	Exhibit 17, Stop-Loss Contract, Articles II and III, Batestamp No. 270; Tuccitto Depo. 73:7-74:7.
12. Under the Stop-Loss Insurance Contract, after the premiums were paid, Great-West had the duty to pay Earth Systems, Inc. as contract holder, a benefit equal to the excess under either the specific stop-loss benefit or the aggregate stop-loss benefit.	Exhibit 17, Stop-Loss Contract, Articles II and III; Batestamp No. 270; Fry Depo. 46:14-47:3, 57:15-58:5, 96:3-17.
13. The Stop-Loss Contract by its terms did not create any rights or obligations on the part of Great-West with respect to persons covered under the Plan or their beneficiaries.	Exhibit 17, Stop-Loss Contract, Article VIII, Batestamp No. 273; Tuccitto Depo. 74:17-75:9.
14. The Stop-Loss Insurance Contract between Great-West and Earth Systems, Inc. was amended twice, the last being on	Exhibit 19, Batestamp No. 280; Brown Depo. 98:12-101:3, 102:1-103:2.

September 16, 1991. The specific stop-loss amount in Schedule A was increased. It was increased to $75,000. This stop-loss insurance remained in effect until December 31, 1993.	
* * *	
16. Effective December 31, 1993, the Services Agreement with Great-West was not renewed, and the Stop-Loss Contract was terminated.	Tuccitto Depo. 31:9-20; Fry Depo. 45:17-46:22.
17. Commencing on January 1, 1994, Earth Systems, Inc. Employee Benefits Plan purchased insurance through Prudential Care, which now administers the new ERISA Health Care Plan for the employees of Earth Systems, Inc. It is not self-funded.	Brown Depo. 30:11-31:18, 32:19-22.
18. The Stop Loss Insurance Contract in Schedule A which was effective August 1, 1991 through December 31, 1993, provided that "all money recovered by Great-West under the right of recovery provision will be distributed as follows: (1) first to Great-West, to be applied	Exhibit 19, Stop-Loss Contract Amendment, Pg. 2, Schedule A, Batestamp No. 281.

to reduce Great-West's payments of specific stop loss benefits to the contract holder, pursuant to Article II of this contract; (2) secondly, to Great-West to be applied to reduce Great-West's payment of aggregate stop loss benefits to the contract holder, pursuant to Article III of this contract; and (3) thirdly to the contract holder."

19. The Stop-Loss Contract stated as amended, "Nothwithstanding anything to the contrary expressed or implied herein, Great-West shall have the sole right to make claims under the right of recovery provision contained in the Plan. In its sole discretion, Great-West may litigate, negotiate, settle, compromise, release or waive any such claim. The contract holder signs to Great-West all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim."

Exhibit 19, Stop-Loss Contract Amendment, Schedule A, Batestamp Nos. 280-281.

20. The Stop-Loss Contract provided the sharing of legal expenses, on a pro rata basis, between Earth

Exhibit 19, Stop-Loss Contract Amendment, Schedule A, Batestamp No. 281.

Systems, Inc., the contract holder and Great-West, depending on the outcome of the litigation.

21. Timely notice of the following legal proceedings was given to the legal department of Earth Systems, Inc. agent for process designated in the summary plan description and to Great-West: (1) On March 26, 1997, Defendant's "Notice of Motion and Motion to Approve Settlement and Petition for Order Directing the Money to be Paid to the Janette Knudson Special Needs Trust (Probate Code §3611) and for Order Approving Settlement, Including Disbursement for MediCal and Others Disputed Creditors; Declaration of Janette Knudson and Jeffrey S. Pop, attached hereto, Points and Authorities; Exhibit 11 and (Proposed) Order filed separately and concurrently herewith scheduled for April 23, 1997;" (2) On July 3, 1997, a similar Motion Petition and Order as described in (1) above was noticed for hearing on July 23, 1997; (3) on

Stipulation of Undisputed Facts by the Parties; Declaration of Jeffrey S. Pop; Exhibit 3, Summary Plan Description 1991 and Service Agreement, Batestamp No. 22-195; Exhibit 5, Judge Farrell's July 23, 1997 Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (Probate Code § 3611) and for the Order approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors, Batestamp Nos. 197-212; Exhibit 15, Pop Letter to Tuccitto at Great-West, enclosing client's trust account check no. 2033 for $13,828.70, Batestamp Nos. 263-265; Exhibit 48, Order Granting Plaintiff's Motion to Remand, Batestamp No. 1077-1084; Exhibit 50, Order Denying Plaintiff Ex Parte Application for Temporary Restraining Order, Batestamp No. 1087-1090.

July 9, 1997, James M. Ideman, United States District Judge, issued an order denying Plaintiffs Great-West and Earth Systems, Inc.'s Ex Parte Application for Temporary Restraining Order in Case No. 97 3745 JMI (JGx); (4) on July 23, 1997, Judge Farrell issued an Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (Probate Code §3611) and for Order Approving Settlement, including Disbursement for MediCal and Other Disputed Creditors; (5) on August 1, 1997, the Order Approving the Settlement and Establishment of Janette Knudson Special Needs Trust and Notice of Order was mailed to Plaintiffs; (6) on August 21, 1997, by letter to Great-West, Assistant Recovery Manager, Tuccitto, Pop issued a client's trust check as ordered by Superior Court in the amount of Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) to Great-West. A copy of the letter was sent by Plaintiffs' counsel.

22. Plaintiffs received notice of the Conditional Release of all Claims attached as Exhibit 2 to the Petition. The Conditional Release stated in part: "The Defendants agree to pay the above-referenced sum of money to settle this disputed and vigorously defended claim. The payment is allocated as partial compensation for Plaintiff due to her catastrophic losses after deduction of attorneys fees and costs as follows: Past Loss of Earnings and Present Value of Future Loss of Earnings: 5%
Past Medical Expense: 5%
Present Value of Future Medical Expense: 45%
Lifetime Housing, Transportation, Modifications and Accessories: 5%
Loss of Enjoyment of Life Distress and Long Term Disability: 40%
Total: 100%

Exhibit 38, Notice of Motion and Motion to Approve Settlement and Petition for Order Directing the Net Money to be Paid to the Janette Knudson Special Needs Trust (Probate Code § 3611) and For Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors; Declaration of Janette Knudson and Jeffrey S. Pop Attached Hereto; Points and Authorities; Exhibit 11; and [Proposed] Order Filed Separately and Concurrently Herewith.

The Exhibits included: The Special Needs Trust, Batestamp Nos. 706-726, Conditional Release of All Claims, Batestamp Nos. 728-734; Robert Johnson & Associates Economic Report, Batestamp Nos. 736-742; Gerry Aster Rehabilitation Care Costs, Batestamp Nos. 744-752; Dr. Thomas Hedge's Medical Report, Batestamp Nos. 751-768.

23. The Petition before State Court included Economist, Robert W. Johnson's Report which indicated the present value of the future cost of Ms. Knudson's medical expenses are $2,593,900 and that the present value and for future loss of earnings for Ms. Knudson is $818,829.00.	Exhibit 38, Robert Johnson Economic Report, Batestamp No. 736.
24. The Petition for State Court also included an estimation of rehabilitation and care cost by Jerry Aster, Rehabilitation Consultant (Exhibit 4) and Medical Report by Thomas L. Hedge, Jr., M.D. of the Pacific Region Spine and Head Injury Care System, Center for Rehabilitation Medical Center, Northridge Hospital Medical Center (Exhibit 5). These reports confirmed the catastrophic and permanent injuries, Janette Knudson, a quadriplegic received and the future medical problems and needs which are required.	Exhibit 38, Notice of Motion and Motion to Approve Settlement and Petition for Order Directing the Net Money to be Paid to the Janette Knudson Special Needs Trust (Probate Code § 3611) and For Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors; Declaration of Janette Knudson and Jeffrey S. Pop Attached Hereto; Points and Authorities; Exhibit 11; and [Proposed] Order Filed Separately and Concurrently Herewith. This Exhibit includes Conditional Release of All Claims, Batestamp Nos. 728-734; Robert Johnson & Associates Economic Report, Batestamp Nos. 736-742; Gerry Aster Rehabilitation Care Costs, Batestamp Nos. 744-752; Dr. Thomas Hedge's Medical Report, Batestamp Nos. 751-768 and the Special Needs Trust, Exhibit 38, Batestamp Nos. 706-726.

25. The Summary Plan Description in the provision for Right of Recovery states, in part, "We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the covered person receives from: . . . the third party; or . . . the third party's insurer or guarantor; or the covered person's uninsured motorist insurance. This lien will not exceed: • The amount of benefits paid under this booklet for the treatment of the loss; or • The amount received by the covered person for such medical treatment from the third party. The Summary Plan Description (Exhibit 3) and the language under the Right to Recovery Provision was before the Superior Court.	Exhibit 25, Summary Plan Description, Batestamp No. 391; Exhibit 38, Provision for Right of Recovery, Batestamp Nos. 769-775; Exhibit 3, Summary Plan Description and Service Agreement 1991, Batestamp Nos. 22-195.

26. The Summary Plan Description identifies "Denise Shelton, Human Resources Manager for Earth Systems, Inc." as the Plan Administrator for Plaintiff, Health and Welfare Plan for the Employees of Earth Systems, Inc.	Exhibit 25, Summary Plan Description, Batestamp No. 108; Brown Depo. 138:3-11.
27. Denise Shelton has given no interpretation of the Right to Recovery provision in the Summary Plan Description for Plaintiff, the Health and Welfare Plan for Employees of Earth Systems, Inc.	Brown Depo. 34:6-35:6

* * *

29. Trustee Brown admitted that the Janette Knudson Special Needs Trust is not a "covered party" as defined in the Plan. In fact, the term "covered party" is defined in the Summary Plan Description as "covered person" means you and those of your dependents who are covered under this booklet.	Brown Depo. 205:24-206:6; Exhibit 25, Summary Plan Description, Article VI, Batestamp No. 390.
30. Judge Farrell's Order Approving Settlement ordered (1) that the Janette Knudson Special Needs Trust,	Exhibit 5, Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (*Probate Code* § 3611)

Dated March 23, 1997, is approved and shall be established and administered in accordance with its terms and conditions; (2) that Janette Knudson has special needs as defined in Probate Code § 3604, etc., and that the disbursement to the Janette Knudson Special Needs Trust, as set forth in Paragraph 4, is substantially less than the present value of the future medical expenses of Janette Knudson as established by evidence set forth in Exhibits 3, 4 and 5 attached to the Petition.	and for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors, Batestamp No. 197-212.
31. Judge Farrell, in his Order, in Paragraph 6 of Exhibit 5, specifically found that the allocation of the net settlement proceeds is fair and approved. The Court by its order considered the evidence of the present value of the future medical expenses and the present value of the future loss of earnings. The Judge then compared the value of the future medical expenses, based on a forty-	Exhibit 5, Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (*Probate Code* § 3611) and for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors, Batestamp No. 197-212.

five (45%) percent allocation, as compared to the amount allocated to Great-West for past medical expenses and loss of earnings. The Court found that these relationships demonstrate that Great-West has been provided a proper percentage of the settlement for the portion of reimbursement for past medical expenses actually recovered.

32. The Court Order in Paragraph 6 recited that the health insurance policy, under which the initial medical payments for benefits were paid had been reviewed. The Court found that the reimbursement to Great-West is limited to the amount of the net settlement received by Knudson for reimbursement of her past medical expenses and that the payment of $13,828.70 was fair and proper.

Exhibit 5, Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (*Probate Code* § 3611) and for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors, Batestamp No. 200-201.

33. On August 21, 1997, Jeffrey S. Pop, by client trust account, disbursed funds to Medi-Cal and Great-West, as ordered by the Court. The Janette Knudson Special Needs Trust was funded directly by Defendant Hyundai in the amount of $260,015.88, as ordered by the Court.

Exhibit 15, Pop letter dated August 21, 1997 to Tuccitto, Batestamp Nos. 263-265; Stipulation of Undisputed Facts by the Parties.

34. The Petition and supporting exhibits provided Great-West and Earth Systems, Inc. of notice that Plaintiff Knudson was requested by Superior Court to interpret the Summary Plan Description Right to Recovery Provision in order to enforce her right to have a limit placed on the amount of the lien.

Stipulation of Undisputed Facts by the Parties; Declaration of Jeffrey S. Pop dated March 26, 1997, ¶ 's 11-22, Batestamp Nos. 699-703; Exhibit 38, Petition, ¶ 's 10-15, Batestamp Nos. 683-687; Declaration of Janette Knudson dated March 28, 1997, Batestamp Nos. 692-695.

35. The Summary Plan Description under the provision for Right to Recovery established a first lien which was limited by the following language:

"This lien will not exceed:

- The amount of Benefits paid under this booklet for the treatment of the loss; or
- The amount received by the Covered person for such medical treatment from the third party.

Exhibit 25, Summary Plan Description dated January 1, 1992 IV-7, Batestamp No. 774.

36. The allocation of the settlement proceeds as set forth in the conditional release of all claims and as adopted by Judge Farrell is just and fair in light of the complex disputed nature of the claim against Hyundai and the permanent and lifetime care requirements for Janette Knudson, a quadriplegic and the relationship of the total loss to the net benefits available in settlement.	Exhibit 5, Order Approving Settlement and Petition Directing the Net Monies to be Paid to the Janette Knudson Special Needs Trust (*Probate Code* § 3611) and for Order Approving Settlement Including Disbursement for Medi-Cal and Other Disputed Creditors, Batestamp No. 197-212;
37. On April 22, 1997, Great-West filed in Superior Court a Notice of Removal in the case styled *Knudson v. Hyundai Motor of America, Inc., et al.* Case No. LC022329.	Stipulation of Undisputed Facts by the Parties, Federal District Court File, Case No. 97-2801 JMI (ANx); Exhibit 46, Petition for Removal, Batestamp Nos. 1071-1072; Exhibit 47, Batestamp No. 1076-1078; Exhibit 54, Great-West filed an Answer and Counter Claim, Batestamp Nos. 1129-1130.
38. On April 22, 1997, Great-West filed a Petition for Removal in the case styled *Knudson v. Hyundai Motor of America, Inc., et al.; Great-West Life & Annuity Insurance Company, Counter-Plaintiff v. Janette Knudson, Counter Defendant*, Case No. CV 97-2801 JMI (ANx).	Stipulation of Undisputed Facts by the Parties, Federal District Court File, Case No. 97-2801 JMI (ANx); Exhibit 46, Petition for Removal, Batestamp Nos. 1073-1075; Exhibit 47, Batestamp No. 1076-1078; Exhibit 54, Great-West Answer of Counter Claim, Batestamp Nos. 1129-1130.

39. Between April 22, 1997 and June 30, 1997, Knudson through her attorney made Motion for Remand and Great-West through their attorney filed an Opposition to the Motion for Remand. Great-West filed an Answer and Counter Claim against Janette Knudson in the case styled *Knudson v. Hyundai Motor of America, Inc., et al.; Great-West Life & Annuity Insurance Company, Counter-Plaintiff v. Janette Knudson, Counter Defendant*, Case No. CV 97-2801 JMI (ANx).	Stipulation of Undisputed Facts by the Parties, Federal District Court File, Case No. 97-2801 JMI (ANx); Exhibit 46, Petition for Removal, Batestamp Nos. 1073-1075; Exhibit 47, Batestamp Nos. 1076-1078; Exhibit 54, Great-West Answer of Counter Claim, Batestamp Nos. 1129-1130.
40. On June 30, 1997, this Court granted Plaintiff's Motion to Remand and ordered the action remanded to Los Angeles Superior Court.	Exhibit 48, Order signed by James M. Ideman, United States District Judge, Batestamp No. 1079-1084.

CONCLUSIONS OF LAW

1. State Courts have concurrent (forum) jurisdiction to apply ERISA law to adjudicate 29 U.S.C. § 1132(a)(1)(B) issues. 29 U.S.C. § 1132(a)(1)(2).

2. In determining that Janette Knudson did not have to repay the full $411,157.11 in order to fully and completely satisfy her obligations under the Right to Recovery provision in the Summary Plan Description, the State Court was enforcing Janette Knudson's 29 U.S.C. § 1132(a)(1)(B) right not to pay more in reimbursement

than she had recovered from the third party tortfeasor for "such medical treatment."

3. The State Court has already determined the ERISA lien issue. Plaintiffs' failure after notice to subrogate or to enforce their alleged rights preclude them from re-litigating the same issues in this case.

* * *

6. The Make Whole Rule mandates that the insured party be made whole for injury or damages suffered before an insurance company recovers benefits it paid to the insured party. The compromised settlement did not make Janette Knudson whole. *Barnes v. Indep. Auto Dealers* 64 F.3d 1389 (9th Cir. 1995) The Summary Plan Description of a right to first lien upon any recovery is limited by its terms to the amount received by the covered person for such medical treatment from the third party. The Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) is a fair apportionment. *Mongeluzo v. Barter Travenol Long Term Disability Benefit Plan* 46 F.3d 938 (9th Cir. 1995)

* * *

8. An ERISA (Health) Plan may be amended only be [sic] written amendment. 29 U.S.C. § 1102, *Borst v. Chevron* 36 F.3d 1308 (5th Cir. 1994) rehearing and suggestion for rehearing en banc denied, 42 F.3d 639, certiorari denied 115 S.Ct. 1699, 514 U.S. 1066, 131 L.Ed.2d 561 (1994). Any oral amendment which adds or deletes words from the plan is void and cannot be relied upon by Plaintiffs. Therefore, Trustee Brown's declaration which did not consider the limitation on the amount of lien is

similar to an oral amendment deleting the language which stated that "This lien will not exceed: . . . or the amount received by the covered person for such medical treatment from the third party." This is *not* possible.

9. 29 U.S.C. § 1022 requires a Summary Plan Description (SPD) be furnished to "participants and beneficiaries" of any employee benefit plan. 29 U.S.C. §§ 1021(a) and 1022. Therefore, Defendant Knudson has the right to rely upon the information in the document.

* * *

11. 29 U.S.C. § 1103(c) prohibits the assets of an ERISA Plan inuring to the benefit of the employer. The Stop-Loss Agreement between Earth Systems, Inc., the employer, and Great-West, the insurance company, provides for any recovery under the Right to Recovery provision to benefit Great-West and then to Earth Systems, Inc. but not the ERISA Plan. This agreement violates this ERISA provisions. 29 U.S.C. 1103(c).

12. 29 U.S.C. § 1106(a)(1)(D) prohibits a fiduciary from engaging in a transaction if he knows or should know that such transaction constitutes a direct or *indirect* . . . transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan. The transfer of rights under the provision for the Right of Recovery by the employer to Great-West benefits a party-in-interest. A fiduciary cannot indirectly aid the employer to violate the anti-inurement rule.

* * *

16. Defendant Knudson is entitled upon application and proof to reasonable attorney fees and costs pursuant to 29 U.S.C. § 1132(9)(e) and 1132(9)(i).

Dated: February 2, 1998

JEFFREY S. POP & ASSOCIATES

By: /s/ Jeffrey S. Pop
Jeffrey S. Pop, Esq.

Attorneys for Defendatn [sic]
JANETTE KNUDSON

IT IS SO ORDERED

DATED 5/18/98

JAMES M. IDEMAN
UNITED STATES DISTRICT JUDGE

DEFENDANT'S STATEMENT OF
UNCONTROVERTED FACTS

Thomas H. Lawrence, TN Bar No. 17105
OGLETREE, DEAKINS, NASH, SMOAK
& STEWART, P.C.
SunTrust Center, Suite 800
424 Church Street
Nashville, TN 75201-7812
(615) 254-1900,
(615) 254-1908 fax

Attorneys for Plaintiffs
Great-West Life & Annuity Insurance Company,
the Health and Welfare Plan for Employees of
Earth Systems, Inc., and Earth Systems, Inc.,
the Plan Administrator for the Health and
Welfare Plan for Employees of Earth Systems, Inc.

JEFFREY S. POP & ASSOCIATES
Jeffrey S. Pop, Esquire – State Bar #054343
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462, (310) 274-7749 fax

Attorneys for Defendant
Janette Knudson

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYEES OF EARTH SYSTEMS, INC. Plaintiffs, v. JANETTE KNUDSON, an individual; ERIC KNUDSON, an individual Defendants.	CASE NO. CV-97-3745 JMI (Jgx) **STIPULATION OF FACTS BETWEEN THE PARTIES** (Judge James M. Ideman) FILED 98 FEB 13

Thomas H. Lawrence, Esquire on behalf of GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, THE HEALTH AND WELFARE PLAN FOR EMPLOYERS OF EARTH SYSTEMS, INC. AND EARTH SYSTEMS, INC., THE PLAN ADMINISTRATOR FOR THE HEALTH AND WELFARE PLAN FOR EMPLOYERS OF EARTH SYSTEMS, INC., Plaintiffs and Jeffrey S. Pop, Esquire on behalf of JANETTE KNUDSON, Defendant, hereby stipulate to the following facts which are *not* disputed:

1. On March 26, 1997, Jeffrey S. Pop, on behalf of Janette Knudson, sent by mail a document entitled "NOTICE OF MOTION AND MOTION TO APPROVE SETTLEMENT AND PETITION FOR ORDER DIRECTING THE NET MONEY TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE CODE* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDI-CAL AND OTHER DISPUTED CREDITORS; DECLARATION OF JANETTE KNUDSON AND JEFFREY S. POP ATTACHED HERETO; POINTS AND AUTHORITIES; EXHIBIT 11; AND [PROPOSED] ORDER FILED SEPARATELY AND CONCURRENTLY HEREWITH". The foregoing document was received by mail and/or Express Mail by Great-West Life & Annuity Insurance Company ("Great West"). The Notice of Motion stated that the hearing date for the Motion was April 23, 1997 in Superior Court.

2. On April 22, 1997, Great-West filed a Notice of Filing Notice of Removal in State Court and a Notice of Removal in Federal Court and thereby removed the action to Federal District Court in Case No. CV 97-2801-JMI (Anx);

3. On June 30, 1997, the Order granting Plaintiff's Motion to Remand and Order Remanding Action to Superior Court was filed by the United States District Judge, James M. Ideman;

4. On July 3, 1997, Plaintiff Janette Knudson renoticed and filed in Superior Court, Case No. LC 022329 a "NOTICE OF MOTION AND MOTION TO APPROVE SETTLEMENT AND PETITION FOR ORDER DIRECTING THE NET MONEY TO BE PAID TO THE JANETTE

KNUDSON SPECIAL NEEDS TRUST (*PROBATE COURT* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDI-CAL AND OTHER DISPUTED CREDITORS; POINTS AND AUTHORITIES IN SUPPORT THEREIN; DECLARATION OF JEFFREY S. POP IN SUPPORT THEREOF." The Notice of Motion stated that the hearing date was July 23, 1997. The foregoing documents were mailed to, and received by, both Great-West and Earth Systems, Inc.

5. On or about July 8, 1997, Great-West Life and Earth Systems, Inc., Plaintiffs, made an Ex Parte Application for Temporary Restraining Order in Case No. CV 97-3745 JMI (Jgx) and served the Verified First Amended Complaint on Janette Knudson and her attorney, Jeffrey S. Pop, along with the Ex Parte Application for Temporary Restraining Order;

6. On July 9, 1997, James M. Ideman, United States District Judge, issued an Order denying Plaintiff's Ex Parte Application for Temporary Restraining Order in Case No. 97-3745 JMI (Jgx);

7. On July 23, 1997, Judge Farrell issued an ORDER APPROVING SETTLEMENT AND PETITION DIRECTING THE NET MONIES TO BE PAID TO THE JANETTE KNUDSON SPECIAL NEEDS TRUST (*PROBATE CODE* § 3611) AND FOR ORDER APPROVING SETTLEMENT INCLUDING DISBURSEMENT FOR MEDI-CAL AND OTHER DISPUTED CREDITORS.

8. On August 1, 1997, the ORDER APPROVING THE SETTLEMENT AND THE ESTABLISHMENT OF THE JANETE KNUDSON SPECIAL NEEDS TRUST was

mailed to, and received by, both Earth Systems, Inc. and attorneys for Great-West.

9. On August 21, 1997, by letter to Great-West, Assistant Recovery Manager, Louis A. Tuccitto, Pop issued a client's trust check in the amount of Thirteen Thousand Eight Hundred Twenty-Eight Dollars and Seventy Cents ($13,828.70) to Great-West. A carbon copy of the letter was sent to and received by counsel for Plaintiffs.

10. On August 22, 1997, Attorney Lawrence faxed to Attorney Pop a letter notifying him that all funds should be segregated pending the outcome of the Federal Court case.

11. On August 22, 1997, Attorney Pop faxed and mailed a letter to Attorney Lawrence informing him that the monies Attorney Pop received had been disbursed and the Special Needs Trust was funded directly by Hyundai.

The foregoing facts as to the timing of events are undisputed and hereby stipulated to by the parties.

Dated:
February 9, 1998

JEFFREY S. POP & ASSOCIATES

By: /s/ Jeffrey S. Pop
Jeffrey S. Pop, Esq.

Attorneys for Defendant
Janette Knudson

Dated:
February 9, 1998

OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.

By: /s/ Thomas H. Lawrence
Thomas H. Lawrence, Esq.

Attorneys for Plaintiffs
GREAT-WEST LIFE &
ANNUITY INSURANCE
COMPANY, ET AL.

[Proof Of Service Omitted In Printing]

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et al., Plaintiffs, v. JANETTE KNUDSON, et al., Defendants.	CV 97-3745 JMI (JGx) ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT FILED MAY 18 1998

IT IS HEREBY ORDERED:

The following motions came before the Court on March 23, 1998:

Plaintiff's Motion For Summary Judgment;
Plaintiff's Motion For Preliminary Injunction;
Plaintiff's Motion To Disqualify Defendant's Counsel;
Plaintiff's Motion To Strike Defendant's Jury Demand;
Plaintiff's Motion To File Second Amended Complaint;

Defendant's Request For Judicial Notice;
Defendant's Motion For Summary Judgment.

Pursuant to Federal Rule of Civil Procedure 78 and Central District of California Local Civil Rule 7.11, the Court dispensed with oral argument on the motions, and Court took the motions under submission. After careful and exhaustive review, considering all pertinent papers

on file, the arguments, and materials presented by the parties, the Court hereby takes judicial notice of requested documents, GRANTS Summary Judgment in favor of Defendants, and DENIES the remaining motions.

BACKGROUND

This action arises under the Employee Retirement Income Security Act of 1974 ("E.R.I.S.A."), codified at 29 U.S.C. § 1001, *et seq.* Plaintiff Great-West Life & Annuity Insurance Company ("Great-West") is the assignee for collection of the health and welfare plan for employees at Earth Systems, Inc. ("Earth Systems"). Defendants are Janette and Eric Knudson, husband and wife. Mr. Knudson was an employee of Earth Systems when he and his wife were involved in an automobile accident which left Mrs. Knudson a quadriplegic for life.

The Health and Welfare Plan for Employees of Earth Systems ("The Plan") paid out $411,157.11 in medical benefits for Janette Knudson's medical care. The Plan had a "Stop-Loss" insurance agreement with Great-West, whereby the Plan would pay any benefits up to $75,000 and Great-West would pay any excess amount. Additionally, the stop-loss allowed Great-West the right to recover first from amounts paid to the Plan by third parties. The stop-loss limits the Plan's risk of dissipating all of its assets for a single member.

Defendants in 1993 sued Hyundai Motors of America, and others, in L.A. Superior Court. Though Plaintiff Great-West was the assignee with rights of subrogation on an E.R.I.S.A. funded policy, it did not at any time seek to intervene in that action. Instead, when the Knudsons

and Hyundai agreed on a $650,000.00 settlement and notified Great-West that the Superior Court would rule on the fairness of the settlement and status of liens on the settlement, Great-West removed that case to federal court (*Knudson, et al. v. Hyundai Motors of America, Inc., et al.*, CV 97-2801 JMI (ANX)). This Court remanded that case because Great-West, a non-party in that action, had no right to remove the case.

At the same time, Plaintiffs filed the instant action (probably to hedge their bets against remand in the other case). Plaintiff Great-West alleges that it is entitled to $411,157.11 of any settlement proceeds because it paid out that amount in plan benefits to pay for medical expenses. Because the E.R.I.S.A. plan provided for first-lien reimbursement of medical expenses recovered from third parties, Plaintiff Great-West argues that it is entitled to injunctive relief.

Following remand, the Superior Court considered the fairness of the settlement and the status of creditors' liens on settlement funds. The settlement agreement, which provided $650,000.00 to the Knudsons, allocates damages as follows:

Loss of Earnings	5%
Past Medical Expense	5%
Future Medical Expense	45%
Loss of Enjoyment of Life; Distress; Long-Term Disability	40%
Other	5%

Because past medical expenses reflect only five per cent of the settlement amount, Plaintiff Great-West was not entitled to full subrogation under the settlement agreement. By Orders on July 23, 1997 and August 1, 1997 the Superior Court approved the settlement and directed payment of funds to the Janette Knudson Special Needs Trust and to disputed creditors. Under the authorized settlement, Knudson's attorney sent a check to Great-West for $13,828.70, five percent of the settlement. Great-West did not cash the check, but requested that Knudson's attorney segregate all of the settlement funds pending the outcome of the present case in Federal Court. Knudson's attorney refused because monies had gone directly from Hyundai to the Knudson Special Needs Trust. Plaintiff's Motion for injunctive relief seeks segregation of the disbursed funds and attorney's fees.

ANALYSIS

The Court decides the motions in the following order because the ruling on certain motions obviate the need to consider the remaining motions:

I. Defendant's Request for Judicial Notice;

II. Cross Motions For Summary Judgment;

III. Plaintiff's Motion To Strike Defendant's Jury Demand;

IV. Plaintiff's Motion For Preliminary Injunction;

V. Plaintiff's Motion To Disqualify Defendant's Counsel;

VI. Plaintiff's Motion For Leave To File a Second Amended Complaint;

I. Defendant's Request for Judicial Notice

Defendant Janette Knudson requests that the Court take judicial notice of certain pleadings and orders of *Knudson v. Hyundai*, Los Angeles county Superior Court Case No. LC 022329 and District Court Case No. 97-2801 JMI (Anx) (while removed and prior to remand). Federal Rule of Evidence 201 allows a court to take judicial notice of pleadings, orders, and decisions by the same or other courts. *See Papai v. Harbor Tug and Barge Co.*, 67 F.3d 203 (9th cir. 1995).

This Court takes judicial notice of the documents associated with motions and orders approving settlement in Superior Court and the file compiled while the case was removed to this Court.

The Court does not expressly rule on the parties' evidentiary objections. However, the Court thoroughly considered each, where pertinent, and disregarded inadmissible evidence. The Court did not base its conclusion on evidence that the Court would deem inadmissible at trial. *Hal Roach Studios v. Richard Feiner & Co.*, 896 F.2d 1542, 1555 (9th Cir. 1990).

II. Cross Motions For Sumary Judgment

Preemption and Exclusive Jurisdiction under ERISA

Defendant Janette Knudson was a "Covered Person" under the Plan. The parties agree that ERISA preempts the substantive state law governing this action. Plaintiffs, however, maintain that ERISA also gives the federal courts exclusive jurisdiction over this dispute, and that the Superior Court lacked subject matter jurisdiction to determine lien rights as defined by the Plan. Further, Plaintiffs argue that they could not pursue their claims for reimbursement in the state court because federal courts have exclusive jurisdiction over actions where a plan seeks equitable relief.

The ERISA statute defines the scope of jurisdiction over ERISA disputes: "State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1) (B) and (7) of subsection (a) of this section." 29 U.S.C. § 1132(e) (1). Paragraph (1) (B) states that a beneficiary may bring a civil action "to enforce rights under the terms of the plan." 29 U.S.C. 1132(a) (1) (B). The state court action to determine the status of liens on Janette Knudson's recovery is an action to enforce her rights under the terms of the Earth Systems Plan.

Plaintiffs note that "State courts have concurrent jurisdiction over ERISA claims *only* if the claim is one by a participant against a plan where the participant is seeking to recover benefits under 29 U.S.C. § 1132(a) (1) (B)." Plaintiff's Points and Authorities, at p.3 n.2 (emphasis added). Plaintiffs misstate the law. The concurrent jurisdiction includes more than "only" what Plaintiffs allege.

See Schwarzer, et al., *Cal. Prac. Guide: Fed. Civ. Pro. Before Trial* § 2:38 (TRG 1998) (citing *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 (1983)). The statute clearly states that concurrent jurisdiction includes actions to recover benefits, to enforce rights under the terms of the Plan, and to clarify future benefits.

Plaintiffs correctly state that the federal courts have exclusive jurisdiction over an ERISA case seeking injunctive relief. 29 U.S.C. § 1132(e) (1). Plaintiffs seek injunctive relief in this Court but never intervened in the state court action. The fact that Plaintiffs might have sought injunctive relief, does not deprive the state court of jurisdiction to enforce legal rights under the plan. Likewise, the fact that Plaintiffs may have mistakenly thought the state court lacked jurisdiction, does not strip that court of jurisdiction.

Therefore, the Court finds that the Superior Court had subject matter jurisdiction to determine the status of liens on Knudson's recovery.

Standard for Summary Judgement

A motion for summary judgment provides a procedure for terminating without trial actions in which "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). It is the moving party's burden to show the district court that there is an absence of essential evidence to support the opposing party's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). The court must view the evidence presented in the motion in the light most favorable to the opposing party.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). However, the judge's function is not to weigh the evidence and determine the truth of the matter, but to determine whether there is a genuine issue for trial. *Id.* at 249-255.

The Plan's Reimbursement Rights

Plaintiff claims that the terms of the Plan provide for full, first lien, reimbursement to the extent of benefits paid from amounts recovered by the covered person form [sic] third parties. Based on this reading of the Plan, Plaintiffs contend that Knudson should have to pay the first $411,157.11 of any recovery to Plaintiffs. Plaintiffs state that a covered person's allocation of settlement funds is irrelevant to the determination of reimbursement rights where a benefit plan defines the scope of those rights.

Defendant Knudson argues that the Plan expressly limited Plaintiffs recovery to the amount paid out for medical expenses. Because the settlement allocated 5% of the total recovery for past medical expenses, Defendant refuses to pay more than the five percent, less attorneys fees.

The Earth System Plan states that the Plan will pay benefits to a covered party, even when a third party may be liable, but reserves a right of recovery as follows:

> "We will, at our sole option, have the right to recover from the Covered Person any payment for benefits paid for treatment of such Loss under this Booklet which the Covered Person is entitled to receive from the third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person receives from . . . [third parties].
>
> The lien will not exceed:
>
> – the amount of benefits paid under this Booklet for the treatment of Loss; or
>
> – the amount received by the Covered Person for such medical treatment from the third party."

Exhibit B to Plaintiff's Motion for Summary Judgement. [sic]

The Right of Recovery Agreement Signed by Eric Knudson

In addition to the terms of the Plan, the Plan required that Eric Knudson sign a "Right of Recovery Agreement" prior to the Plan paying any of Janette Knudson's medical bills. *See* Exhibit 16 to combined motions. Unlike the terms of the Plan, the Agreement states that the Plan will have the right to reimbursement from "any" third party recovery and an automatic first lien.

The Agreement contains a number of flaws that render it useless for the purposes of the motions presently before the Court. First, the Agreement clearly misstates the rights as established by the Plan. Second, the Agreement purports to be made in consideration of the Plan paying benefits under the Plan. The Plan cannot use a preexisting obligation as consideration for a later contract. Finally, the terms of the Plan, itself, forbid alteration of the obligations without formally amending the official Plan documents. A plan administrator cannot amend a plan to divert resources from a beneficiary to the employer. *Jacobson v. Hughes Aircraft Co.*, 105 F.3d 1288,

1292 (9th Cir. 1997). Because the Right of Recovery Agreement misstates the terms and obligations of the Plan, it is appropriate that the Court disregard the Right of Recovery Agreement in determining Plaintiffs rights under the Plan.

Interpretation of the Plan

The terms of the Plan authorize the Plan Administrator to interpret the language of the Plan. Courts will not upset the administrator's interpretation of an ERISA plan unless the interpretation is arbitrary and capricious. *Canseco v. Construction laborers Pension Trust For Southern California*, 93 F.3d 600, 606 (9th Cir. 1996). In this case, Jerol Brown, an employee of Earth Systems, was vested with the authority to interpret the Plan. Mr. Brown interpreted the Plan to allow the Plan through Great-West, as the stop loss carrier, to be reimbursed 100% of any third party recovery. Based on Mr. Brown's interpretation, Great-West, the Plan, and Earth Systems seek to recover all of the $411,157.11 for Defendant's settlement with Hyundai. An interpretation of a plan which imposes additional terms which clash with the terms of a plan is considered arbitrary and capricious. *Id.* Mr. Browns's interpretation of the Plan clashes with the terms of the Plan. A reviewing court should not defer to an interpretation of the Plan that is flawed. *Atwood v. Newmont Gold Co. Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995).

The terms of the Plan are abundantly clear in providing for a first lien and limits of reimbursement. Under the facts of the present case, the Plan is limited to recovering no more than the amount of benefits paid out or the

amount received from a third party for medical treatment. Therefore, Plaintiffs may recover the lesser of, the $411,157.11, or the portion of the $650,000 that is attributable to medical expenses.

Since the Superior Court had proper jurisdiction and concluded that five percent of the settlement is attributed to Plaintiffs' lien, that matter is resolved.

Therefore, Defendants are entitled to summary judgement [sic] finding that five percent of the settlement is allocated to medical expenses.

III. Plaintiff's Motion To Strike Defendant's Jury Demand

The present claim is brought under the ERISA statute, which has been construed not allow for a jury trial. *Spinelli v. Gaughan*, 12 F.3d 853, 857 (9th Cir. 1993). at § 16.45. The right to a jury trial in federal court is a matter of federal law. In this case, where the statutory remedy is more analogous equity, the parties are not entitled to a jury trial. *See Id.*

The Court finds it unnecessary to strike the jury demand in light of the ruling on summary judgment.

IV. Plaintiffs' Motion For Preliminary Injunction

Plaintiffs seek a preliminary injunction to prevent Knudson, her attorney, and the trustee of the Janette Knudson Special Needs Trust from dissipating settlement funds before Plaintiffs are able to obtain a final ruling in the present suit.

The court denies this motion in light of the ruling on summary judgment.

V. Plaintiff's Motion To Disqualify Defendant's Counsel

Plaintiffs move to disqualify Jeffery S. Pop, and the law firm of Jeffrey S. Pop & Associates (collectively "Pop") from representing Defendant Knudson in this action because a conflict of interest exists. Under the terms of Knudson's insurance policy, Plaintiffs have a lien on the proceeds of her personal injury settlement. Pop acknowledged the lien in a letter to Plaintiffs in September 1995. Plaintiffs reason that by acknowledging the lien and then distributing the settlement proceeds as ordered by the Superior Court, Pop created some sort of conflict of interest.

Plaintiffs do not adequately explain their allegations of multiple representation and conflict of interest. The California Bar Rules require written disclosure to a client when the bar member's relationships or interests will affect the representation of the client. *See* California Bar Rules, Professional Conduct Rule 3.31(B). There is no evidence that the mere existence of a lien creates such a relationship. Even if such a situation was created by the facts of this case, the Rules would merely obligate Pop to provide written disclosure.

Plaintiffs further allege that Pop's contingent fee agreement creates a conflicting financial interest. The fee agreement is itself a written disclosure, resolving any potential conflict.

The motion appears meritless.

VI. Plaintiff's Motion For Leave To File Second Amended Complaint

The Court denies this motion in light of the ruling on summary judgment.

CONCLUSION

Summary Judgment is hereby GRANTED in favor of Defendants.

The Court adopts the stipulation of facts between the parties filed on February 13, 1998.

The Court finds law and facts as stated above. Additionally, the Court adopts Defendants' Statement of Law and Facts lodged on February 2, 1998. The Court strikes the following findings because they are either unsupported or unnecessary in the resolution of the present motions:

Uncontroverted facts 2, 15, and 28;

Conclusions of law 4, 5, 7, 10, 13, 14, and 15.

IT IS SO ORDERED.

DATED: May 14, 1998

/s/ James M. Ideman
James M. Ideman
United States District Judge

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et. al., Plaintiffs-Appellants,

v.

Janette KNUDSON and Eric Knudson, Defendants-Appellees.

No. 89-56472.
D.C. No. CV 97-03745-JMI.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Sept. 13, 1999.

Decided Feb. 7, 2000.

Appeal from the United States District Court for the Central District of California, James M. Ideman, District Judge, Presiding.

Before B. FLETCHER, PREGERSON, Circuit Judges, and WEINER,[2] Senior District Judge.

MEMORANDUM[1]

Great-West Life & Annuity Insurance Company ("Great-West"), Earth Systems, Inc. and the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. appeal the district court's judgment adverse to them in their action seeking to enforce a contractual reimbursement provision pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA")

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[2] Charles R. Weiner, Senior United States Judge for the Eastern District of Pennsylvania, sitting by designation.

[1] This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as may be provided by Ninth Cir. Rule 36-3.

§ 502(a)(3), 29 U.S.C. § 1132(a)(3) against Janette and Eric Knudson ("Knudson"). We affirm the district court's judgment but do so on grounds different from those relied on by the district court.

Defendants Eric and Janette Knudson were involved in an auto accident, which left Janette a paraplegic. At the time of the accident, she was covered by the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. ("the Plan"). Following the accident, the Plan paid benefits totaling $411,157.11 to Knudson and her medical providers. The Plan includes a reimbursement provision giving the Plan a right to recover third party payments to Knudson up to the amount of the benefits paid by the Plan. The Plan also had a "Stop-Loss" insurance agreement with Great-West which gave Great-West the right to recover first any amounts reimbursing the Plan. Knudson was required also to execute an agreement to reimburse as a condition of receiving payments under the Plan.

Knudson filed suit in state court against Hyundai Motors and others allegedly responsible for the accident. The parties settled for $650,000. The state court ultimately approved the settlement and resolved the status of various competing lienholders to the settlement.[3] The settlement attributed five percent of the award to prior medical

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[3] Prior to the state court's final approval of the settlement, Great-West removed the action to federal district court. The district court remanded to state court, noting that Great-West was never a party to the state court action. None of the issues surrounding the removal are before the panel in this appeal and neither party has appealed the state court ruling.

expenses. Knudson's attorney sent a check to Great-West for $13,828.70, representing 5% of the award. Rather than accept this amount, Great-West, Earth Systems, and the Earth Systems Plan filed suit in federal district court claiming entitlement to $411,157.11 of the settlement.

Ruling on cross-motions for summary judgment,[4] the district court held that the plain terms of the Plan limited the Appellants' reimbursement to the amount received by Plan beneficiaries from third parties for medical treatment. Because the state court oversaw the settlement and awarded Knudson only $13,828 for medical treatment, the district court simply acknowledged that the Appellants' right to reimbursement was limited to that amount. The court granted summary judgment in favor of Knudson. The district court also granted Knudson's request for attorneys fees in the amount of $80,497.50.

ERISA provides fiduciaries an exclusive forum in federal courts to enforce provisions of an ERISA plan. See 29 U.S.C. § 1132(e)(1). The Appellants seek to bring an action under 29 U.S.C. § 1132(a)(3) which requires that they be seeking equitable, rather than legal relief. We held, in FMC Medical Plan v. Owens, 122 F.3d 1258, 1262 (9th Cir.1997), that reimbursement of payments made to a beneficiary of an insurance plan by a third party, which

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[4] Motions for preliminary injunction, disqualification of counsel, the striking of the jury demand, for judicial notice, and to file an amended complaint were also before the district court judge. In this appeal, Great-West has not challenged the district court's rulings with respect to the motions.

Appellants seek here, is not equitable relief within the meaning of § 1132(a)(3).[5]

Appellants contend that Owens was wrongly decided and seek en banc review. However, we have recently reaffirmed the holding in Owens and, therefore, decline to seek en banc review. See Reynolds Metals Co. v. Robert Ellis, ___ F.3d ___ (9th Cir.2000).

We also affirm the district court's award to Knudson of attorneys fees in the amount of $80,497.50.[6] Even in the absence of subject matter jurisdiction, a district court has the power to award attorneys fees. See Moore v. Permanente Medical Group, Inc., 981 F.2d 443 (9th Cir.1992).

Accordingly we affirm the district court's judgment.

AFFIRMED.

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[5] Owens rests its dismissal on the lack of subject matter jurisdiction. But see Cement Masons Health and Welfare Trust Fund for Northern California v. Stone, 197 F.3d 1003, 1008 (9th Cir.1999) (reaffirming the substantive holding in Owens but dismissing on the merits rather than on subject matter jurisdiction). For our purposes, in evaluating the substantive holding of Owens requiring the dismissal of reimbursement claims for third party settlements under ERISA, the dismissal could be based either on lack of subject matter jurisdiction or on the merits.

[6] Appellants challenge the right to attorneys fees, not the amount.

May 10, 2001

No. 99-1786 (13)

Supreme Court, U.S.
FILED
MAY 10 2001
OFFICE OF THE CLERK

In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR PETITIONERS

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, D.C. 20007
(202) 965-8100

THOMAS H. LAWRENCE
JOHN M. RUSSELL
HALE HEADRICK DEWEY WOLF GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

DAVID C. ASPINWALL
GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
8515 East Orchard Road
Greenwood Village, Colorado 80111

Counsel for Petitioners

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

49 pp

QUESTION PRESENTED FOR REVIEW

Whether federal courts have jurisdiction over actions brought by ERISA plan fiduciaries to enforce recoupment provisions in ERISA plans against plan participants or beneficiaries for medical expenses paid for injuries caused by third-party tortfeasors.

LIST OF PARTIES

The caption of the case in this Court contains the names of all the parties. Petitioners amend the corporate disclosure statement in their Petition for a Writ of Certiorari to state that Petitioner Great-West Life & Annuity Insurance Company has as a parent a publicly held company, Great-West Lifeco, Inc., which has as parent corporations Power Financial Corporation of Canada and Power Corporation of Canada, all of which are publicly traded on the Toronto Stock Exchange.

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OPINIONS BELOW

This action was initiated by Petitioners in the United States District Court for the Central District of California, and that court entered summary judgment in favor of Respondents. The order granting summary judgment is reprinted in J.A. 237-49.[1] There is no official citation to that order. The Petitioners moved for reconsideration of that order and Respondent Janette Knudson moved for an award of attorney's fees under ERISA. The district court granted the motion for attorney's fees and denied Petitioners' motion for reconsideration. The order disposing of these motions is reprinted in Appendix D to the Petition for a Writ of Certiorari.

Petitioners appealed to the United States Court of Appeals for the Ninth Circuit, case number 98-56472, and that Court entered an opinion on February 7, 2000. The opinion is reprinted in J.A. 250-53. The citation for the unpublished opinion is *Great-West Life & Annuity Insurance Company, et al. v. Knudson*, No. 98-56472, 2000 WL 145374 (9th Cir. Feb. 7, 2000), 208 F.3d 221 (9th Cir. 2000) (table).

Respondent Janette Knudson moved for attorney's fees under ERISA, and Petitioners filed a Suggestion for Rehearing *En Banc*. On March 22, 2000, the Ninth Circuit denied the Suggestion for Rehearing *En Banc*. On April 3,

---

[1] The district court's order granting summary judgment should be read in conjunction with its previous order granting Respondents' motion to remand the related state court action that was previously removed to federal court and remanded to state court. The district court's remand order is reprinted in J.A. 171-75. There is no official citation to that order.

2000, the Court denied Respondent's motion for attorney's fees.

BASIS FOR JURISDICTION IN THIS COURT

This action was filed in the United States District Court for the Central District of California. The court entered summary judgment in favor of Respondents. Petitioners timely appealed to the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit entered its order on February 7, 2000. Petitioners filed a Suggestion for Rehearing *En Banc*, which was denied on March 22, 2000.

The petition for a writ of certiorari was timely filed on May 9, 2000 under Supreme Court Rule 13(1), and this Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS, TREATIES, STATUTES, ORDINANCES, AND REGULATIONS INVOLVED

29 U.S.C. § 1132(a)(3):

> (a) Persons Empowered to Bring Civil Action
>
> A civil action may be brought –
>
> * * *
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other

> appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan; . . . .

28 U.S.C. § 1331:

> Federal question –
>
> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

STATEMENT OF THE CASE

At the time of the automobile accident giving rise to the payment of medical benefits at issue here, Eric Knudson was an employee of an Earth Systems, Inc. ("Earth Systems") subsidiary. He and his wife, Janette Knudson, were covered persons under the Health and Welfare Plan for Employees and Dependents for Earth Systems, Inc. (the "Plan"). The Plan was self-funded by Earth Systems. Great-West Life & Annuity Insurance Company ("Great-West") acted as the claims service administrator for the Plan (J.A. 24, 32) and issued stop-loss insurance coverage that reimbursed the employer for claims in excess of $75,000 per year with respect to the loss in question. J.A. 33, 48.[2]

Mrs. Knudson's accident happened in June, 1992, when she lost control of the Hyundai automobile she was driving, which left the road and rolled over several times,

[2] Petitioners are the Plan, Earth Systems, and Great-West.

leaving her a quadriplegic. J.A. 112. The Plan paid benefits to Mrs. Knudson and/or her medical providers in the amount of $411,157.11 for her medical care. J.A. 238. In 1993, Mrs. Knudson and her husband filed suit in California Superior Court against the third parties allegedly responsible for her injuries, the car's manufacturer and distributors. J.A. 238. Petitioners were not parties to that lawsuit. J.A. 238-39. That action was ultimately settled for $650,000. J.A. 139-44.

This case involves the enforcement of a specific Right of Recovery provision of the Plan, which entitles Earth Systems to recoup the benefits paid on behalf of Knudson from that third-party recovery. The Plan in pertinent part provides:

> A third party may be liable or legally responsible for expenses incurred by a Covered Person for an illness; or a sickness; or a bodily injury.
>
> When this happens we will, subject to all other terms and provisions of this Booklet, pay any benefits which are payable for the expenses incurred by the Covered Person for the treatment of such illness, sickness or bodily injury (the "Loss").
>
> RIGHT OF RECOVERY. We will, at our sole option, have the right to recover from the Covered Person any payment for benefits paid for treatment of such Loss under this Booklet which the Covered Person is entitled to receive from the third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the Covered Person receives from:

> The third party; or the third party's insurer or guarantor; or the Covered Person's uninsured motorists insurance.
>
> This lien will not exceed:
>
> the amount of benefits paid under this Booklet for the treatment of the Loss; or
>
> the amount received by the Covered Person for such medical treatment from the third party.
>
> CONDITIONS:
>
> The Covered Person must cooperate fully with us in asserting our right to recover. If the Covered Person: – makes any recovery as set forth in this provision; and – fails to reimburse us fully for any benefits paid under this provision; then he will be personally liable to us to the extent of such recovery up to the amount of the first lien.
>
> Before any benefits are paid for the treatment of such Loss under this Booklet, we may require the Covered Person to provide all information and sign and return all documents necessary to exercise our rights under this provision.

J.A. 58-59.

After Mrs. Knudson was injured, her husband signed a Right of Recovery Agreement on behalf of his disabled spouse, which states:

> As a member of the above named Plan, I have made a claim for covered medical expenses under the terms of the Plan for myself or dependent for the injury/illness detailed above. . . .

> I request that benefits be paid at this time without the necessity of awaiting final determination of responsibility. . . .
>
> I also understand that under the terms of the Plan, the Plan may recover from me any payments for benefits paid under this Plan for which I or my dependents may be entitled to receive from a third party. The Plan shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise, that I or my dependents receives from another party, the other party's insurer or guarantor, or my own insurer or guarantor. Said first lien shall be for the amount of medical and hospital benefits paid by the Plan, I shall be personally liable to the Plan to the extent of such recovery up to the amount of its first lien. I agree to cooperate fully with the Plan in asserting its right to recover.

J.A. 77-78.

After the Knudsons acknowledged their obligations, Earth Systems paid $411,157.11 in benefits on Mrs. Knudson's behalf. If Eric Knudson had not signed the Right of Recovery Agreement, the Plan would not have paid for Mrs. Knudson's medical treatment. J.A. 69.

As the Knudsons' third-party action progressed, Mrs. Knudson's counsel and a representative from Great-West,[3] Louis Tuccitto, discussed resolution of Petitioners' right of recoupment. Mrs. Knudson's counsel was sent,

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[3] The discretionary responsibility for enforcing the Plan Right of Recovery provision had been assigned to Great-West by Earth Systems, a fiduciary of the Plan. J.A. 48.

on February 7, 1994, a copy of the Summary Plan Description containing the Right of Recovery provision. J.A. 54-66. Her counsel sent Great-West a letter on September 29, 1995, acknowledging Earth Systems' lien. Brief of Appellants, filed in the Ninth Circuit, at p. 11.

Despite this acknowledgment, Mrs. Knudson's attorney sought to compromise the lien in connection with settlement of the third-party action. *Id.* After learning that Mrs. Knudson was recovering $650,000 because of her injuries, Petitioners offered to reduce their lien by accepting $200,000 instead of $411,157.11, with Mrs. Knudson's counsel accepting $200,000 as an attorney's fee, and the remaining $250,000 being paid to Mrs. Knudson. *Id.* Mrs. Knudson's attorney refused. *Id.*[4]

On March 27, 1997, after these efforts at compromise failed, the Knudsons mailed to Great-West a motion to approve settlement in their third-party action, which was pending in California Superior Court. J.A. 233. They, however, did not serve Great-West (or Earth Systems) with a summons in that action. Brief of Appellants, filed in the Ninth Circuit, at p. 11. On April 22, 1997, Great-West removed to the United States District Court for the Central District of California the claims asserted against it, based upon 28 U.S.C. § 1441(c) and the "complete preemption" doctrine under ERISA. J.A. 167-70. On June 30, 1997, the district court remanded those claims to state court, holding that Great-West was not a party-defendant

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[4] Ultimately, Mrs. Knudson's attorney received $373,426 of the $650,000 settlement for fees and costs. J.A. 141.

in the state court action nor "in a position to itself oppose Plaintiffs' motion for approval." J.A. 171-75.

On May 19, 1997, Petitioners filed the present action, which was amended on July 7, 1997, and thereafter served on the Knudsons. J.A. 81-95. On July 9, 1997, the district court denied, based, in part, upon the Anti-Injunction Act, Petitioners' application for temporary restraining order. J.A. 96-99.

On July 23, 1997, the California Superior Court approved the settlement of Knudsons' state court action against the third parties allegedly responsible for Mrs. Knudson's injuries. J.A. 139-44. In that settlement, the parties allocated only $13,828.70 of the $650,000 settlement to repayment of the $411,157.11 in past medical expenses. J.A. 141. The Petitioners were not parties to that settlement proceeding.

In December, 1997, Petitioners moved for summary judgment, moved for leave to file their Second Amended Complaint to add Jeffrey S. Pop, his law firm, and Louise Curinga, Trustee of the Special Needs Trust, as defendants, and moved for preliminary injunction against the new parties. J.A. 7-9. The Knudsons filed their cross-motion for summary judgment. J.A. 11-13.

On May 18, 1998, the district court granted Knudsons' motion for summary judgment and denied Petitioners' motion for summary judgment. J.A. 237-49. Because it granted summary judgment to Respondents, the court did not consider Petitioners' motion for leave to file a Second Amended Complaint. J.A. 249. Petitioners then filed a motion for reconsideration. J.A. 19. On July

10, 1998, the district court denied the motion for reconsideration and granted Janette Knudson's motion for attorney's fees pursuant to ERISA § 502(g)(1). J.A. 21; Appendix D to the Petition for a Writ of Certiorari.

Petitioners timely appealed to the Ninth Circuit, which issued its memorandum decision on February 7, 2000. J.A. 250. The Ninth Circuit affirmed the district court's judgment, but did "so on grounds different from those relied on by the district court." J.A. 251. Rather than reaching the merits of any of Petitioners' multiple arguments that the district court had erred, the Ninth Circuit, citing its prior decision in *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1262 (1997), concluded that reimbursement of payments made to an ERISA plan beneficiary was not "appropriate equitable relief" within the meaning of ERISA § 502(a)(3). J.A. 252-53. According to that decision, a plan's claim for "equitable reimbursement" from a plan participant's third-party recovery was not cognizable under ERISA § 502(a)(3) because (1) the "substance of the remedy sought" was for monetary relief and (2) restitutionary claims under § 502(a)(3) were limited by this Court in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), to the return of "ill-gotten" gains. The Ninth Circuit's rejection of Petitioners' ERISA claim, it noted, could be regarded as "based either on lack of subject matter jurisdictions or on the merits [*i.e.*, ERISA provided no cause of action]." J.A. 252, 53 & n.5.

SUMMARY OF THE ARGUMENT

The relief sought by the Petitioners in this case – the enforcement of the Earth Systems Plan's reimbursement provision against Plan participants and beneficiaries – is provided by § 502(a)(3) of ERISA which authorizes actions "(A) to enjoin any act or practice which violates . . . the terms of [a] plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . the terms of [a] plan." Claims to enjoin the violation of the Plan's reimbursement provision and to enforce its terms by requiring reimbursement from the Knudsons of the amounts in question fit precisely within the plain language and meaning of § 502(a)(3).

The holding of the Ninth Circuit in this case and *Owens* is based on an erroneous characterization of a claim seeking enforcement of a plan reimbursement provision as one which is seeking "money damages" rather than "appropriate equitable relief" within the meaning of § 502(a)(3). Such a characterization fails to distinguish between an award of money damages as compensation for an injury and compelling the performance of a contractual promise that happens to be a promise to pay money. In *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250 (2000), this Court stated that the term "appropriate equitable relief" in § 502(a)(3) should be guided by common law principles. Compelling the performance of a monetary obligation has been characterized consistently as equitable relief and distinguished from money damages under common law, although the precise label attached to such equitable relief has varied from case-to-case and court-to-court, but

has included "mandatory injunction," "specific performance," "restitution," "equitable lien," and "constructive trust." Indeed, drawing largely on common law principles, the Courts of Appeals for the Seventh, Eighth, and Eleventh Circuits have attached such labels to relief sought in actions seeking enforcement of reimbursement provisions similar to the one at issue in this case.

This Court, itself, has specifically distinguished between money damages and equitable remedies which involved the payment of money. *See, e.g., Bowen v. Massachusetts*, 487 U.S. 879 (1988). Moreover, it has recognized that, for purposes of § 502(a)(3), an unquestionably equitable remedy – "constructive trust" – could be applied to recover money for a plan from a party who had not obtained such funds by either fraud or wrongdoing. *See, e.g., Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. at 251.

The Ninth Circuit's holding also erroneously relies on this Court's holding in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), that "appropriate equitable relief" as used in § 502(a)(3) does not include ***compensatory money damages***. *Mertens*, unlike the present case, clearly involved a claim for compensatory money damages, *i.e.*, monetary relief for all losses sustained by a plan as a result of an actuarial firm's allegedly wrongful failure to change the plan's actuarial assumptions, causing the plan to be underfunded and eventually terminated. Moreover, this Court stated that "appropriate equitable relief," for purposes of § 502(a)(3) means those remedies traditionally thought of as equitable relief and typically available in equity, such as injunction, mandamus, and restitution. Compelling the performance of a contractual

promise has traditionally been characterized as equitable relief, even if the contractual promise involves the payment of money.

As this Court also recognized in *Varity v. Howe*, 516 U.S. 489, 515 (1996), the meaning of the term "appropriate equitable relief" should for purposes of § 502(a)(3) be interpreted to the extent possible to be consistent with the purposes of ERISA as well as its literal language and the common law of trusts. An interpretation of § 502(a)(3) which permits the enforcement of a vital term of a plan clearly is consistent with ERISA's objectives.

Finally, even if this Court were to find that the relief sought by Petitioners is not firmly grounded in § 502(a)(3), this Court should fashion federal common law to provide such relief in order to fill a clearly unintentional gap in ERISA's civil enforcement scheme – provision of a remedy to enforce a term of a plan that happens to require the payment of money.

ARGUMENT

A. The Relief Sought In This Case Is Specifically Authorized By § 502(a)(3) Of ERISA

In both the present case and *Owens*,[5] the Ninth Circuit held that an action seeking to enforce a plan participant's obligation to pay money to a plan under a reimbursement provision of the plan was not "equitable

[5] *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997).

relief" within the meaning of § 502(a)(3) of ERISA. That section provides as follows:

> (a) A civil action may be brought –
>
> (3) by a participant, beneficiary, or fiduciary (A) ***to enjoin any act or practice which violates*** any provision of this subchapter or ***the terms of the plan***, or (B) ***to obtain other appropriate equitable relief (i) to redress such violations*** or (ii) ***to enforce any provisions of this subchapter or the terms of the plan***[.]

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (emphasis added).

In Petitioners' First Amended Complaint, Petitioners allege that Respondents violated the terms of the Plan by failing to reimburse the Plan, for the cost of medical benefits that the Plan paid to Mrs. Knudson for medical care as a result of her accident, from her recovery of an amount in excess of such benefits in settlement of a claim against third parties who purportedly caused such losses. The first claim for relief in the First Amended Complaint ("Injunction Against Acts and Practices That Violate the Terms of the Plan") states as follows:

> 13. Pursuant to 29 U.S.C. § 1132(a)(3), Plaintiffs seek an injunction against Defendants: (1) to prevent the Defendants from violating the terms of the Plan and (2) to enforce the terms of the Plan.
>
> 14. By not agreeing to reimburse the Plan the amount recovered, Defendants have violated, and therefore breached the terms of the Plan.

> 15. Since this act and/or practice violates the Plan's terms, this Court should enter an order enjoining Defendants and all of those persons in the active concert or participation with them, from violating the Plan's terms.
>
> 16. Specifically, the Court should enjoin Defendants and all those in active concert or participation with them, to reimburse the Plan in the amount of $411,157.11 out of any proceeds they recovered from third parties.

J.A. 92.

Such a claim squarely falls within the language of § 502(a)(3) which authorizes an action "(A) to enjoin any act or practice which violates . . . the terms of [a] plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . the terms of [a] plan. . . . " Nothing in § 502(a)(3)(A) expressly or impliedly prohibits the injunctive relief authorized by that provision from including an injunction requiring a plan participant to pay money which it is obligated to pay under the terms of a plan (or, put another way, the payment of which is necessary to cure a violation of the terms of the plan).

Longstanding equitable principles hold that an injunction can take the form of a requirement that a party perform some ***affirmative*** act, rather than forbid a party from engaging in certain conduct. 1 Dan B. Dobbs, Law of Remedies: Damages – Equity – Restitution § 2.9(1), at 224 (2d ed. 1993). For example, in order to enjoin a party from violating a contractual duty, a court may order a ***mandatory injunction*** that compels the party to carry out some positive act of performance. *Id. See also* 3 *id.* § 12.8(1), at

190 (noting that the remedy of specific performance is a form of mandatory injunction in which the court orders the defendant to perform the contract). *Cf.* 4 J. Pomeroy, Equity Jurisprudence § 1692 (4th ed.) ("restraining the breach of a contract by injunction is merely a mode of specifically enforcing the contract[, thus] the discretion of the court in awarding the injunction is guided by the same equitable principles and doctrines as those which regulate the remedy of specific performance.").

The Petitioners' First Amended Complaint specifically seeks ***to enjoin Respondents from violating the terms of the Plan's reimbursement provision*** and to enforce such terms by requiring the Respondents to pay the Plan the settlement proceeds to which the Plan is entitled under such terms. Accordingly, they have stated a claim for relief which is available under the plain meaning of § 502(a)(3).[6]

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[6] Under accepted principles of statutory construction, it should be inferred from the reference in § 502(a)(3)(B) to "***other*** appropriate equitable relief" that the relief authorized in § 502(a)(3) "to enjoin any act or practice which violates . . . the terms of [a] plan" is, itself, "appropriate equitable relief." *See, e.g.*, 2A Norman J. Singer, Statutes and Statutory Construction § 46:05, at 154 (6th ed. 2000) ("[E]ach part or section should be construed in connection with every other part or section so as to produce a harmonious whole. . . . "); *id.* at 165 ("[A] statutory subsection may not be considered in a vacuum, but must be considered in reference to the statute as a whole and in reference to statutes dealing with the same general subject matter . . . "); *id.* § 46:06 at 181-190 (" 'It is an elementary rule of construction that effect must be given, if possible, to every word, clause and sentence of a statute.' A statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant,

B. Petitioners Seek A Form Of Relief Traditionally Recognized As Equitable In Character

The U.S. Court of Appeals for the Ninth Circuit held in this case and *Owens* that § 502(a)(3) of ERISA allows a fiduciary to seek relief to enforce the terms of a plan but does not permit such relief to include the recovery of money, except perhaps in the form of restitution of "ill-gotten" assets or profits taken from a plan through fraud or wrongdoing. *Owens*, 122 F.3d at 1261. The Ninth Circuit's holding in these cases relies principally upon its interpretation of this Court's decision in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), in which the Court held that the phrase "appropriate equitable relief" as used in § 502(a)(3) does not include ***compensatory money damages.***

1. *Mertens* Authorizes, Rather than Bars, the Type of Relief Sought in this Case

Mertens involved an action against a nonfiduciary actuarial firm to recover losses to a plan allegedly resulting in the actuarial firm's failure to change the plan's actuarial assumptions, causing the plan to be underfunded and eventually to be terminated. 508 U.S. at 250. As the Court stated, the relief sought in *Mertens* was "nothing other than compensatory damages – monetary

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and so that one section will not destroy another unless the provision is the result of obvious mistake or error.") (internal citation and footnotes omitted).

relief for all losses [the] plan sustained as a result of the alleged breach of fiduciary duties." *Id.* at 255.

Petitioners argued that the relief they sought was "equitable relief" because under the common law of trusts, relief for breaches of trust, including compensatory damages, was obtained in courts of equity. The Court rejected that argument. *Id.* at 255-256. Rather, the Court interpreted the term "equitable relief" for purposes of § 502(a)(3) to mean those remedies traditionally thought of as equitable relief and typically available in equity "***such as injunction***, mandamus, and restitution" as distinguished from legal relief, such as compensatory money damages, which would generally be beyond the scope of an equity court's authority. *Id.* at 256 (emphasis added). Nowhere in *Mertens* does the Court even suggest that the term equitable relief ***never*** includes the payment of money. As demonstrated hereafter, the types of relief referred to by this Court in *Mertens* as examples of equitable relief often include the award of monetary relief other than compensatory money damages. Moreover, it is clear by the use of the term "such as" that this Court did not interpret § 502(a)(3) as limiting "appropriate equitable relief" to only injunction, mandamus, and restitution and as excluding other traditional forms of equitable relief like specific performance.[7]

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[7] Moreover, *Mertens* does not address the language of ERISA § 502(a)(3)(A) which authorizes actions "to enjoin any act or practice which violates . . . the terms of [a] plan," which is relief expressly sought in this case. *See supra* pp. 12-14.

The present case is clearly distinguishable from *Mertens*. Unlike *Mertens*, in which the relief sought was clearly compensatory money damages – a classic form of legal remedy – the Petitioners in this case seek to enjoin Respondents from violating their Plan's reimbursement provision. Requiring Respondents to reimburse the Plan under its reimbursement provision could be and has been appropriately characterized by other federal Courts of Appeals as "mandatory injunction," "specific performance," "restitution," and "constructive trust" and is precisely the type of relief authorized by the language of § 502(a)(3) and falls within the types of traditional equitable relief noted by this Court in *Mertens*.

2. An Action Seeking to Enjoin or for the Specific Performance of an Obligation is a Typical Form of Equitable Relief, Even if the Obligation Involves the Payment of Money

In this case, the Petitioners seek to require the performance by Mrs. Knudson of her obligation under the terms of the Plan to reimburse the Plan for medical benefit payments from the amounts that she recovered in settlement of an action against third parties allegedly responsible for her injuries in an auto accident. Contrary to the Ninth Circuit's characterization of such an action as one for ***money damages*** for breach of contract, this Court, consistent with longstanding common law jurisprudence, has characterized such a remedy to be one for equitable relief that happens to involve the payment of money.

In *Bowen v. Massachusetts*, 487 U.S. 879 (1988), for example, the Court explicitly distinguished between an action seeking "money damages" of the sort that it disallowed under § 502(a)(3) in *Mertens* and a suit seeking specific enforcement of an obligation to reimburse money. In *Bowen*, the State of Massachusetts sought reimbursement from the Federal Department of Health and Human Services ("HHS") of services performed by Massachusetts agencies that purportedly were reimbursable under Medicaid. HHS argued that the district court which originally awarded Massachusetts the relief it requested lacked jurisdiction to award such relief pursuant to § 702 of the Administrative Procedure Act which bars the district court's review of actions against federal agencies seeking "money damages." The Court held that the state's action for reimbursement was not one for damages. In so doing, the Court explicitly distinguished between the remedy, "money damages" and a remedy of "specific performance" which involved the payment of money:

> Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies 'are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled.' D. Dobbs, Handbook on the Law of Remedies 135 (1973). Thus, while in many instances an award of money is an award of damages, 'occasionally a money award is also a specific remedy.' *Id.* Courts frequently describe equitable actions for monetary relief under a contract in exactly those terms. *See, e.g., First*

> *National State Bank v. Commonwealth Federal Savings & Loan Association*, 610 F.2d 164, 171 (3d Cir. 1979) (specific performance of contract to borrow money); *Crouch v. Crouch*, 566 F.2d 486, 488 (5th Cir. 1978) (contrasting lump-sum damages for breach of promise to pay monthly support payments with an order decreeing specific performance as to future installments); *Joyce v. Davis*, 539 F.2d 1262, 1265 (10th Cir. 1976) (specific performance of a promise to pay money bonus under a royalty contract).

487 U.S. at 895.

The Court, accordingly, recognized that a suit to enforce a statutory mandate for the reimbursement of money to be an ***equitable suit*** for specific monetary relief. *Id.* at 900-901. *See also Albemarle Paper Company v. Moody*, 422 U.S. 405, 416 (1975) (recognizing that an award of backpay is an equitable remedy); *Kross v. Western Electric Company, Inc.*, 701 F.2d 1238, 1244 n.7 (7th Cir. 1983) (finding that an award of backpay constitutes equitable relief under § 502(a)(3), relying on *Albemarle Paper*).

Subsequent to *Bowen* and *Mertens*, in *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000), the Court stated that the construction of the term "appropriate equitable relief" in § 502(a)(3) should be guided by common law principles. *Harris Trust*, 530 U.S. at 250. As this Court recognized in *Bowen*, the specific performance of a monetary obligation has long been recognized under the common law as equitable relief. Professor Dan B. Dobbs, in his Handbook on The Law of Remedies, Damages – Equity – Restitution, recognized that: "When a court orders specific performance it may make money awards as necessary to give complete

relief[.]" Volume 1, § 3.1 at 279 n.8 (2d ed. 1993). Dobbs recognized further that sometimes a money award is also a specific performance remedy. In this regard, Dobbs explained that: "When the plaintiff was never entitled to anything but money, the recovery of an award of money is a kind of [specific performance]." *Id.* at 280.

Likewise, equitable principles specifically allow injunctive orders that compel the payment of money. *Id.* § 2.6(1), at 152. As recognized by the Third Circuit: "It is not unusual for a defendant in equity to expend money in order to obey or perform the act mandated by an injunction. Injunctions, which by their terms compel expenditures of money, may similarly be permissible forms of equitable relief." *United States of America v. Price*, 688 F.2d 204, 213 (3d Cir. 1982); *cf. Penn Terra Limited v. Department of Environmental Resources, Commonwealth of Pennsylvania*, 733 F.2d 267, 278 (3d Cir. 1984) ("in contemporary times, almost everything costs something. An injunction which does not compel some expenditure or loss of monies may often be an effective nullity.").

Other federal Courts of Appeals which have addressed whether the enforcement of a plan reimbursement provision similar to that in the present case is relief authorized under § 502(a)(3) have characterized such a remedy as "specific performance" or "injunctive" relief, which they have held to be "equitable" remedies within the meaning of § 502(a)(3). In so doing, they have expressly rejected the Ninth Circuit's holding and reasoning in *Owens*.

In *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999), the Wal-Mart Associates Health & Welfare Plan

filed suit against Wal-Mart employee Patricia Gauf seeking to compel reimbursement of benefits pursuant to a plan provision requiring reimbursement when employees obtain a third-party tort recovery for damages arising out of the medical condition for which the plan previously paid benefits. As in the present case, the plan sued under ERISA § 502(a)(3) to obtain "other appropriate equitable relief . . . to enforce . . . the terms of the plan."

Gauf argued that the plan was, in effect, seeking a legal remedy because the ultimate purpose of the suit was to obtain reimbursement of money, and thus, its action could not lie under § 502(a)(3). The Seventh Circuit rejected this argument, stating:

> Although the pertinent parts of the complaint employ a variety of terms to express the relief requested, we believe that a fair reading of the document in its totality makes clear that the Committee is seeking an equitable remedy against Ms. Gauf to insure her compliance with the terms of the Plan. For example, the complaint requests "specific performance and enforcement" of the contract and an "order enjoining Defendant from continuing to violate the terms of the Plan."

Id. at 770.

In reaching its conclusion, the *Gauf* court acknowledged the holding of *Owens*, but wholly rejected it, stating that "our Circuit has consistently held that a complaint purporting to state a claim for equitable relief

under a reimbursement clause in a benefits contract is an equitable claim for purposes of ERISA Section 502(a)(3)."[8]

The Eleventh Circuit also rejected the *Owens* decision in *Blue Cross and Blue Shield of Alabama v. Sanders*, 138 F.3d 1347 (11th Cir. 1998). As in *Owens*, *Gauf*, and the present case, the action in *Sanders* arose out of a plan provision permitting the plan to obtain reimbursement in the event the participant obtained a tort recovery against a third party. As in *Gauf*, the defendants relied upon *Owens'* conclusion that a reimbursement claim is an action for legal relief unavailable under § 502(a)(3).

The Eleventh Circuit squarely rejected this argument, stating that:

> *Owens* appears to be based on an unduly narrow reading of *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993). . . . The Court in *Mertens* did not imply that specific performance is unavailable under 29 U.S.C. § 1132(a)(3)(B). Because specific performance is a traditional form of equitable relief, . . . we believe that specific performance may be equitable relief available under 29 U.S.C. § 1132(a)(3)(B).[9]

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[8] 188 F.3d at 771, *citing Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Neurobehavioral Associates, P.A.*, 53 F.3d 172, 173-74 (7th Cir. 1995).

[9] *Id.* at 1352-53 n.5. *See also In re Unisys Corp. Retiree Medical Benefit ERISA Litigation*, 57 F.3d 1255, 1268-69 (3d Cir. 1995).

In *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703 (7th Cir. 1999), another suit in which the plaintiffs were seeking to enforce a welfare plan reimbursement provision similar to the one in the present case, the Seventh Circuit found that such relief was authorized under § 502(a)(3). Besides stating that the plaintiff's reimbursement claim could properly be characterized as an action for a constructive trust, the court held also that it could be characterized as an action seeking "a mandatory injunction directing [the defendant plan participant] to sign over her claim to the money" as well as one for an "equitable lien."[10] *Id.* at 711. The Seventh Circuit found all of these types of relief (*i.e.*, constructive trust, mandatory injunction, and equitable lien) to be "securely equitable." *Id. See also Southern Council of Industrial Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996) (specific performance of a plan's subrogation provision constitutes "appropriate equitable relief" within the meaning of § 502(a)(3)).

The Complaint in the present action seeks an injunction, which, among other things, requires Mrs. Knudson's payment to the Plan of the funds which Mrs. Knudson is obligated to pay under the Plan's reimbursement provision. Consistent with the authorities cited above, the relief which Petitioners seek unquestionably can be characterized as the equitable remedies of either injunction or

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[10] The Plan's reimbursement provision creates a *lien* on the funds recovered by the Knudsons from the third parties allegedly responsible for Mrs. Knudson's injuries, which lien the Respondents are seeking to specifically enforce. First Amended Complaint at ¶¶ 9, 15.

specific performance, and not "money damages" as erroneously characterized by the Ninth Circuit.

3. The Relief Sought in this Case also may Properly be Categorized as "Restitution" or a "Constructive Trust"

The Ninth Circuit presumed that restitution involving the payment of money is only available as "equitable relief" when the money in question constitutes "ill-gotten" assets and stated that the plan participant in *Owens* had not obtained the funds subject to the plan's reimbursement provision "by any fraud or wrong-doing." 122 F.3d at 1261. The retention by plan participants like the Knudsons of the funds at issue in this case in violation of the terms of their Plan constitutes "wrong-doing." In any event, the Ninth Circuit's narrow interpretation of the scope of equitable remedies such as restitution and constructive trust as being limited to the recovery of funds obtained by fraud or other wrongdoing is neither consistent with the common law's treatment of restitution and constructive trust nor this Court's decision in *Harris Trust v. Salomon Brothers*.

Under the common law the equitable remedies of restitution and constructive trust could be utilized by one party to recover assets, including money from another party whenever it would be unconscionable for the latter party to retain and enjoy the use of the assets. As recognized by Dobbs:

> Thus restitution by way of constructive trust may be appropriate for . . . benefits transferred under mistake . . . It is entirely appropriate to

> award a constructive trust as a means of forcing restitution to prevent unjust enrichment. For this purpose, ***it does not much matter how the unjust enrichment came about***. What must give concern is not the method by which the defendant enriched himself, but the fairness and workability of the judicial decree.

Dan B. Dobbs, Handbook on The Law of Remedies, Damages – Equity – Restitution § 4.3, at 246 (1973) (emphasis added). *See also* 5 A. Scott, The Law of Trusts § 462.2 (4th ed. 2000) ("A constructive trust may arise, however, even though the acquisition of the property was not wrongful. It arises where the retention of the property would result in the unjust enrichment of the person retaining it.").

This principle has been specifically applied in the context of the common law of trusts where it has been recognized that when a trust transfers property to a beneficiary it may maintain an equitable action to recover such property if the transfer was in violation of the trust's terms, regardless of whether the beneficiary could appropriately be characterized as a "wrongdoer" or the assets as "ill-gotten gains." *See Counihan v. United States of America*, 194 F.3d 357, 361-62 (2d Cir. 1999) (noting that imposition of a constructive trust does not require the performance of any wrongful act by the enriched party, and affirming district court's imposition of a constructive trust based upon circumstances where "the holder of legal title should not, in good conscience and equity, retain the benefits derived from such title").

Relying on similar common law principles, this Court held in *Harris Trust* that an action under § 502(a)(3) could be maintained against a nonfiduciary party-in-interest

who participated in a transaction prohibited by ERISA § 406(a) although such party had not breached any duty to the plan. 530 U.S. at 245-247. The Court noted that, "[w]henever the legal title to property is obtained through means or under circumstances 'which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same, although he may never, perhaps, have had any legal estate herein.' " 530 U.S. at 250 (*quoting Moore v. Crawford*, 130 U.S. 122, 128 (1889), and 2 J. Pomeroy, *Equity Jurisprudence* § 1053, at 628-629 (1886)).

Another federal Court of Appeals, in enforcing a similar plan reimbursement provision, has expressly rejected the Ninth Circuit's position in *Owens* that restitutionary relief can only be characterized as "equitable" for purposes of § 502(a)(3) when it involves the recovery of money or other assets obtained by fraud or wrongdoing. Thus, in *Health Cost*, the Seventh Circuit found that the enforcement of the plan reimbursement provision, in addition to being properly characterized as an equitable lien or mandatory injunction, could also be characterized as a constructive trust which "is, of course, an equitable remedy." 187 F.3d at 711. The Seventh Circuit dismissed the Ninth Circuit's rejection of this type of relief under § 502(a)(3) as follows:

> So Health Cost is indeed seeking a constructive trust and while the Ninth Circuit appears to believe that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust, *FMC Medical*

> *Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997), it has given no reason for this belief and there is no basis for it either in ERISA or in the principles of equity. Granted that in times of yore the constructive trust was available only as a remedy against trustees and other fiduciaries, 1 Dobbs, *supra*, § 4.3(2), p. 597, there is nothing to suggest that ERISA's drafters wanted to embed their work in a time warp. In ordinary trust law the historical limitation of the remedy has been abandoned. *Id.* at § 4.3(2), pp. 597-98; 5 Austin Wakeman Scott & William Franklin Fratcher, Scott on Trusts § 462 (4th ed. 1989). We do not think the motto of our law should be "let the dead bury the living."

Health Cost, 187 F.3d at 710.

In view of the Knudsons' violation of the terms of the Plan's reimbursement provision and the fact that the failure to enforce their obligation under that provision would leave them unjustly enriched at the expense of the Plan and its other participants and beneficiaries, there can be no doubt that it would be "unconscientious" for them to retain the funds owing to the Plan and that the recovery of such funds would constitute an equitable remedy consistent with the above authorities.

C. Granting The Remedy Sought In This Case Would Be Consistent With ERISA's Purposes

As the U.S. Court of Appeals for the Sixth Circuit has stated, "a primary purpose of ERISA is to ensure the integrity and primacy of the written plans." *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997). *See also Gulf Life Insurance Co. v. Arnold*, 809 F.2d 1520, 1523

(11th Cir. 1987) ("The purpose essential to Section 1132(a)(3)(B) is to enforce the terms of [a] plan . . . "). Affirming the Ninth Circuit's holding in this case, however, would leave the Plan without a remedy to enforce a vitally important provision of the Plan merely because the enforcement of such provision involves the reimbursement of money. Other than § 502(a)(3), no other provision of § 502 can be construed to provide such relief. At the same time, any state law action seeking the enforcement and interpretation of the terms of an ERISA-covered employee benefit plan would unquestionably "relate to [an] employee benefit plan" for purposes of § 514(a) of ERISA, and, accordingly would be preempted under that section.[11] *See Pilot Life Ins. Co. v. Dedeaux*, 481

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[11] Thus, in *Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr. 2d 723 (Cal. Ct. App. 1996), a third-party administrator of an ERISA-covered employee benefit plan sought to recoup benefits paid on behalf of a covered person after the covered person recovered from a third party for the same injuries that had been paid by the plan. The California Court of Appeals reversed the judgment granted in favor of the plan and ordered that the complaint against the plan be dismissed because federal courts have exclusive jurisdiction over recoupment actions brought by ERISA plan fiduciaries:

> [T]he federal courts have exclusive subject matter jurisdiction of civil lawsuits under ERISA, except for actions under Title 29 of the United States Code, § 1132(a)(1)(B) and (a)(7); the state courts have concurrent jurisdiction in matters arising under those sub-divisions. Section 1132(a)(1)(B) and (a)(7) authorize actions, respectively: "by a participant or beneficiary . . . to recover benefit due to him [or her] under the terms of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of

U.S. 41, 47 (1987). Under similar circumstances, this Court has construed § 502(a)(3) in a manner so as to prevent litigants from being deprived of any remedy under circumstances where such a result clearly would be inconsistent with a primary purpose of ERISA.[12]

In *Varity v. Howe*, 516 U.S. 489, 507 (1996), this Court addressed the issue of whether plan participants were authorized under § 502(a)(3) to seek individualized equitable relief for breaches of fiduciary duty. The Court held that such relief was so authorized under § 502(a)(3). In arriving at its decision, the Court concluded that such relief fell within the meaning of the term "appropriate equitable relief." It further found that its interpretation of that term was consistent with the common law of trusts and both ERISA's structure and purpose. In this regard, the Court found that Congress intended § 502(a)(3) to act

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> the plan" and "by a state to enforce compliance with a qualified medical child support order. . . . " Plaintiff is not a plan participant or beneficiary, nor is it a state. Therefore, plaintiff is not a proper party to bring an action in the state court under ERISA, § 1132(a)(1)(B) or (a)(7). In other words, any action plaintiff may be able to bring under ERISA is not a lawsuit as to which this court can exercise concurrent subject matter jurisdiction. In the absence of subject matter jurisdiction, plaintiff's complaint must be dismissed.

Id. at 726.

[12] Respondents concede that they could have brought an action under § 502(a) of ERISA seeking an interpretation of the Plan's reimbursement provision in order to attempt to resist its enforcement. Motion to Dismiss as Improvidently Granted, at pp. 11-12. It would be incongruous and unreasonable to interpret § 502(a) as denying representatives of the Plan a parallel cause of action to enforce the same Plan provision.

as a "safety net" to provide relief which was consistent with ERISA's objectives but that § 502 does not elsewhere provide. 516 U.S. at 512. Recognizing that the protection of plan beneficiaries from breaches of fiduciary duty was a paramount objective of ERISA, the Court concluded:

> We are not aware of any ERISA-related purpose that denial of a remedy would serve. Rather, we believe that granting a remedy is consistent with the literal language of the statute, the Act's purposes, and pre-existing trust law.

Id. at 515.

Another primary objective of ERISA is to ensure the enforcement of the terms of a plan. *See, e.g., Gulf Life Insurance Co. v. Arnold*, 809 F.2d at 1523 ("The purpose essential to Section 1132(a)(3)(B) is to enforce the terms of [a] plan . . . "). Such an objective is manifest in the structure of ERISA which, among other things (i) requires fiduciaries to act in accordance with the terms of a plan,[13] (ii) provides plan participants and beneficiaries with a cause of action to enforce their "rights under the terms of the plan,"[14] and (iii) authorizes participants, beneficiaries and fiduciaries "to enjoin any act or practice which violates . . . the terms of [a] plan" or "to obtain other appropriate equitable relief . . . to redress such violation."[15] Moreover, as demonstrated above, the specific enforcement of the Plan's reimbursement provision constitutes "appropriate equitable relief" with the meaning of § 502(a)(3), particularly as that section is informed by

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[13] ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

[14] ERISA § 502(a)(1)(B).

[15] ERISA § 502(a)(3).

common law principles. Under these circumstances, consistent with the reasoning of *Varity*, it would be incongruous to deprive a Plan fiduciary from enforcing the Plan's reimbursement provision, merely because such enforcement involves the payment of money.

Such a result also would be incongruous with the Court's recent decision in *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001), in which it held that a state law providing for the automatic revocation, upon divorce, of the designation of a spouse as beneficiary of a nonprobate asset was preempted, as it applied to ERISA benefit plans, because it directly conflicted with ERISA's requirement that a plan be administered in accordance with plan documents and interfered with nationally uniform plan administration. Likewise, this Court should not give an unreasonably narrow interpretation to ERISA's own enforcement provisions that would preclude the uniform enforcement of recoupment provisions in accordance with the terms of an ERISA plan.

D. Federal Common Law Also Can Be Applied To Provide The Relief Sought In This Case

A number of federal courts also have concluded that whether or not the requested relief is explicitly authorized under § 502(a)(3), the purposes of ERISA compel them to fashion federal common law to provide a remedy such as that sought by Petitioners.

1. This Court has Authorized Lower Courts to Fill Unintentional Gaps in the Text of ERISA Where Necessary to Provide a Remedy that Furthers the Intended Purpose of the Statute

This Court has held that "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans.' " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (*quoting Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)). When acting under this authority, federal courts are guided by the principles of traditional trust law. *Chemung Canal Trust Co. v. Sovran Bank/Maryland*, 939 F.2d 12, 16 (2d Cir. 1991).

Specifically in conducting an inquiry regarding whether a federal common law remedy should be fashioned, a court should: (1) ascertain the extent to which trust and pension law as developed by state and federal courts provide for recovery by the plaintiff; and if a requested form of additional relief is available under state trust law, then (2) consider whether allowance of such relief would significantly conflict with some other aspect of the ERISA scheme. *Id.* at 18 (*citing Massachusetts Mutual Life v. Russell*, 473 U.S. 134 (1985) (Brennan, J., concurring)). Moreover, courts must bear in mind the ultimate consideration of whether allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA. *Id. See also Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 280 (2d Cir. 1992) (the inquiry "requires a consideration of whether there is a need for interstitial lawmaking and, if so, whether recognizing such a right of action would be

consistent with ERISA's scheme and further its purposes."). Application of these factors to this case permits this Court to fashion a federal common law remedy to provide relief to the Petitioners, should it conclude that ERISA § 502(a)(3) does not already do so.

a. The requested relief is available under established state trust law principles

Petitioners' requested relief, to enjoin Respondents from violating the terms of the Plan's reimbursement provision and to enforce that provision by requiring Respondents to reimburse the Plan from third-party settlement proceeds, is available under state law trust principles. As demonstrated above, injunctive relief is among a number of principles firmly grounded and recognized in trust law that would provide such a remedy. Specifically, a mandatory injunction, "that orders an affirmative act or course of conduct" (1 Dan B. Dobbs, Law of Remedies: Damages – Equity – Restitution § 2.9(1), at 224 (2d ed. 1993), may be ordered to compel the payment of money. *Id.* § 2.6(1), at 152. Moreover, specific performance has been described as "a form of injunctive decree." 3 *Id.* § 12.8(1), at 190, *citing Campbell Inns, Inc. v. Banholzer, Turnure & Co., Inc.*, 527 A.2d 1142, 1144 (Vt. 1987). A specific performance decree, too, may compel the order of money. *See* 1 *id.* § 3.1, at 279 n.8. Similarly, the requested relief can be afforded through the remedy of restitution, a staple in state trust law, to prevent unjust enrichment.

Incorporating any of these traditional trust law doctrines into the law of ERISA would simply be "following the legislative directive to fashion, where Congress has

not spoken, a federal common law for ERISA by incorporating what has long been embedded in traditional trust law and equity jurisprudence." *See Chemung*, 939 F.2d at 16 (concluding that the law of contribution, a traditional trust law right, should be recognized as a part of ERISA).

b. Allowing such relief would not conflict with some other aspect of the ERISA scheme and is necessary to further ERISA's purpose of enforcement of plan terms

Numerous federal courts have recognized that the type of relief sought in this case is grounded in trust law and is not contrary to ERISA's statutory scheme. For example, the Third Circuit has specifically recognized that the authority to develop the federal common law of ERISA "permits application of a federal doctrine of unjust enrichment if restitution would not override a contractual provision of an ERISA plan." *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1186 (3d Cir. 1991) (finding that "to permit restitution here would only further the goals of ERISA, that is to safeguard the corpus of funds set aside under the [plan] for valid [fund] beneficiaries."). *See also State Street Bank and Trust Co. v. Denman Tire Corp.*, 240 F.3d 83, 90 (1st Cir. 2001) (*citing Luby*, and affirming district court's order of restitution, upon concluding that returning disputed fund assets to their rightful owner protects the interest of the pension plan's participants). In the instant case, because the Plan document expressly provides for reimbursement, one who fails to comply with the terms and repay the Plan

those amounts recovered from some third party for the same expenses covered by the Plan has been unjustly enriched. Thus, not only would application of such a trust law doctrine not be *inconsistent* with any contractual provision of the ERISA plan at issue, application is *necessary* for the realization of an intention specifically provided in the Plan. *See Gulf Life Insurance Co. v. Arnold*, 809 F.2d 1520, 1523 (11th Cir. 1987) ("The purpose essential to section 1132(a)(3)(B) is to enforce the terms of the plan of ERISA").

Similarly, the reasoning that prompted the Fourth Circuit in *Provident Life & Accident Insurance Company v. Waller*, 906 F.2d 985 (4th Cir.), *cert. denied*, 498 U.S. 982 (1990), to fashion a federal common law rule of unjust enrichment to be applied to a claim concerning an ERISA plan is wholly applicable here. In *Waller*, the plaintiff, as here, sought repayment of monies advanced to a plan participant. *Id.* at 993. The Court of Appeals concluded that where the plan provided for the repayment of the advanced monies, "the creation of a common law remedy here would further the contract between the parties and effectuate the clear intent of" the clause that specifically called for the repayment. *Id.* Moreover, the *Waller* court recognized that the requested relief was consistent with express rights provided in another ERISA provision, § 403(c)(2)(A), 29 U.S.C. § 1103(c)(2)(A). While that statutory provision allows for the return of mistakenly paid contributions made by employers to multiemployer plan funds, *id.*, the *Waller* court found that the section "indicates a desire to ensure that plan funds are administered equitably and that *no one party, not even plan beneficiaries, should unjustly profit.*" 906 F.2d at 993 (emphasis added).

The Fourth Circuit, thus, concluded that a purpose of ERISA is furthered by fashioning a federal common law rule that ensures that no party is unjustly enriched at the expense of the plan funds. *Id.*

As in *Waller*, the Plan in the instant case specifically provides for the requested relief – reimbursement of monies collected by the plan participant from third parties for the same expenses covered by the Plan. Thus, creation of a common law remedy for a plan fiduciary would further the contract between the parties and effectuate the clear intent of the Plan's reimbursement provision. Moreover, consistent with the conclusion of the Fourth Circuit, the relief sought accords with ERISA's recognized purpose of ensuring that plan funds are administered equitably and that no one party unjustly profits at the expense of the plan. Such relief also is consistent with ERISA's legislative scheme. *See also Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d at 281 (fashioning federal common law right of action for a participant against a nonfiduciary who knowingly participates in an ERISA-fiduciary's breach of duty where "the relief sought here is not inconsistent with ERISA's scheme or the common law of trusts, and furthers ERISA's important purposes.").

2. Application of Federal Common Law is Especially Appropriate Because a Federal Remedy is this Plan's Only Means of Obtaining Relief

The requested relief in this case has been held to "relate to" an employee benefit plan, and is thus preempted. *Jefferson-Pilot Life Insurance Co. v. Krafka*, 57 Cal. Rptr. 2d 723, 726 (Cal. Ct. App. 1996) ("This action alleges a violation of the terms of the plan and is brought to enforce the reimbursement provision of the policy. It follows that the plaintiff's state common law causes of action 'relate to' the plan and are preempted."). *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 47 (recognizing that the phrase "relate to" has been interpreted as having a broad, common-sense meaning to preempt state common law tort and contract causes of action that relate to employee benefits plans). Moreover, ERISA's preemption clause is not limited to " 'state laws specifically designed to affect employee benefit plans.' " *Id.* at 47-48 (internal citation omitted).

When a state law remedy is preempted by ERISA, the federal court has all the more reason to fashion a remedy to provide relief that is consistent with ERISA's principles. *See Diduck*, 974 F.2d at 280-281 ("One factor pointing in favor of preemption is the 'expectation [ ] that a federal common law of rights and obligations under ERISA-regulated plans would develop.' ") (internal citation omitted). In light of ERISA's very broad preemption clause, Congress certainly did not intend to leave fiduciaries without federal remedies that are both *required* for the enforcement of the express terms of plans and *consistent* with the statute's scheme. *See Gulf Life*, 809 F.2d at 1523 ("The

purpose essential to section 1132(a)(3)(B) is to enforce the terms of the plan of ERISA"); *Sokol v. Bernstein*, 803 F.2d 532, 537 (9th Cir. 1986) (*quoting* ERISA legislative history and noting that, "Without question, this language indicates a legislative focus on the direct *protection of plans*, . . . ") (emphasis added). Instead, Congress intended that federal courts would "step in" in instances precisely like the one before this Court, and ensure that plan funds are administered equitably and that no one party, unjustly profits. *Waller*, 906 F.2d at 993.

CONCLUSION

Wherefore, for the foregoing reasons, Petitioners respectfully ask that this Honorable Court reverse the judgment of the Ninth Circuit and remand the matter for further proceedings to determine the amount of reimbursement recovery that Petitioners are entitled to under the Plan reimbursement provision.

Respectfully submitted,

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, DC 20007
(202) 965-8100

THOMAS H. LAWRENCE
JOHN M. RUSSELL
HALE HEADRICK DEWEY WOLF
GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

DAVID C. ASPINWALL
GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY
8515 East Orchard Road
Greenwood Village, Colorado 80111

Counsel for Petitioners Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc.

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IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE CO., EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENT JANETTE KNUDSON

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
Attorneys for Respondent Janette Knudson
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

167896

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

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I. SUMMARY

A. Procedural History.

After Petitioners Great-West Life & Annuity Insurance Company ("Great-West") and Earth Systems Inc. ("Earth Systems") refused to litigate their reimbursement rights in State Court under concurrent jurisdiction pursuant to 29 U.S.C. § 1132(a)(1)(B), 29 U.S.C. § 1132(e)(1),[1] Petitioners then served Janette Knudson with their First Amended Complaint in federal district court ("District Court"). After discovery was completed Petitioners moved for summary judgment, whereupon Respondent Janette Knudson filed a cross motion for summary judgment. The District Court granted Janette Knudson's motion for summary judgment and denied Great-West's motion for summary judgment. The District Court's decision was based upon the application of ERISA legal principles. The Ninth Circuit then affirmed but on other grounds.

B. The ERISA Plan Reimbursement Language.

The Plan contained a provision which limited the reimbursement a participant owed to the ERISA Plan. It stated in relevant part:

---

1. Knudson filed and served a Notice of Hearing and Petition and as described on page 7, which in part was to determine Knudson's lien rights and obligations utilizing federal law under ERISA. Great-West refused to participate in the State Court proceedings. It mistakenly assumed that only federal district courts were empowered to determine the amount of the lien. This assumption lead to a multiplicity of lawsuits. This issue is discussed beginning on page 11, *infra*.

* * *

The lien will not exceed:

• the amount of benefits paid under this **Booklet** for the treatment of the Loss; or

• the amount received by the **Covered Person** for such medical treatment from the third party.

* * *

(J.A. 58-59, bold in original.)

C. Great-West Sues Janette Knudson.

Great-West's first amended complaint was premised on two novel principles. First, that Great-West (not the Plan) could, without any authority and without following procedures mandated by ERISA, unilaterally rewrite the reimbursement provision by sending Janette's estranged husband, Eric Knudson, a letter threatening cessation of payments for necessary medical services unless an adhesive right to recovery agreement was signed. (J.A. 212-213.) The terms of the adhesive right to recovery agreement unfairly modified the beneficiaries duties owed to the Plan. (J.A. 229.)[2]

2. Great-West is a stop loss insurer for the Plan. It explicitly was *prohibited* from: interpreting the language of the Plan, performing any discretionary duties and acting as a fiduciary. (J.A. 28 Article IV.) Clearly, Great-West had no authority under ERISA principles to threaten cessation of medical services unless an adhesive right to recovery agreement was signed by the beneficiary. (J.A. 245-246.)

After this lawsuit was filed, on August 20, 1997 the Plan trustee Jerol Brown attempted *ex post facto* through his interpretation to rewrite the Plan document in order to delete provisions which Brown disfavored. (J.A. 245-247.) Brown admitted that he did not like the provision in the reimbursement clause which limited the amount of recovery to those past medical expenses which were reimbursed from a third party. Brown under his interpretation ignored "limitation" term included in the Plan. (J.A. 246-247.) (K.E.R. Docket 54 at 152-153, 156.)[3]

D. The Outcome Of The Lawsuit At District Court.

The District Court found that the Plan administrator's interpretation was arbitrary and capricious. The District Court also found that Great-West did not have the authority, nor did it receive consideration for attempting to rewrite reimbursement provision of the Plan in the letter and the right to recovery agreement that it forced upon Eric Knudson in 1992. (J.A. 228-229.) The District Court expressly found that both of these actions were arbitrary and capricious and were to be disregarded. (J.A. 228-229.)

* * *

Based on Mr. Brown's interpretation, Great-West, the Plan, and Earth Systems seek to recover all of the $411.157.11 for Defendant's settlement with Hyundai. An interpretation of a plan which imposes additional terms which clash with the terms of a plan is considered arbitrary and

3. K.E.R. refers to Knudson Excerpt of Record filed at the Ninth Circuit Court of Appeals.

capricious. [*Canseco v. Construction Laborers Pension Trust for Southern California*, 93 F.3d 600, 606 (9th Cir. 1996).] Mr. Brown's interpretation of the Plan clashes with the terms of the Plan. A reviewing court should not defer to an interpretation of the Plan that is flawed. *Atwood v. Newmont Gold Co., Inc.* 45 F.3d 1317, 1323 (9th Cir. 1995).

The terms of the Plan are abundantly clear in providing for a first lien and limits of reimbursement. Under the facts of the present case, the Plan is limited to recovering no more than the amount of benefits paid out or the amount received from a third party for medical treatment. . . .

(J.A. 246-247.)

E. Great-West Attacks The Jurisdiction Of Its Own Case After Losing in District Court.

For the first time on December 8, 1998 in its opening brief before the Ninth Circuit Great-West challenged the ERISA jurisdiction of its own lawsuit by raising the issues framed in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997). It should be noted that Great-West failed to raise the *FMC* issue (during pendency of the District Court action) although *FMC* was decided on August 25, 1997.[4]

The Ninth Circuit affirmed the District Court decision primarily based upon the absence of subject matter

4. This raises additional equitable issues for consideration.

jurisdiction. However, the Ninth Circuit in footnote 5 stated that, "For our purposes . . . the dismissal could be based either on lack of subject matter jurisdiction or on the merits." (J.A. 253.)

II. STATEMENT

Janette Knudson was driving a Hyundai in June 1992 when the car went off Interstate 5 at seventy five (75) miles per hour and rolled over several times. (J.A. 145-147.) She instantly became a quadriplegic. (J.A. 147.) Janette Knudson is solely responsible for raising her nine (9) year old daughter, Jenna. (J.A. 112-114.)

The Plan's Right to Recovery provision limited Great-West's lien to amount received for past medical treatment. It states in pertinent part:

RIGHT OF RECOVERY

We will, at our sole option, have the right to recover from the **Covered Person** any payment for benefits paid for treatment of such Loss under this **Booklet** which the **Covered Person** is entitled to receive from a third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, the **Covered Person** receives from:

- the third party; or
- the third party's insurer or guarantor; or
- the **Covered Person's** uninsured motorist insurance.

This lien will *not* exceed:

- the amount of benefits paid under this **Booklet** for the treatment of the **Loss**; or

- the amount received by the **Covered Person** for such medical treatment from the third party.

(J.A. 58-59. Bold in original, italics added.)

Both the State Court *and* the District Court interpreted this language in support of Janette Knudson's position that the lien amount was limited to the amount received for past medicals. Both courts ruled in Janette Knudson's favor based upon the merits of the case. The District Court held that a plan administrator cannot ignore a provision of the Plan which limits recovery. (J.A. 228-229.) Thus, when Great-West ignored the express limit on the recoverable lien, the District Court held that Great-West acted arbitrarily and capriciously. (J.A. 246-247.)

Great-West without authority attempted to modify the ERISA Plan to the detriment of the beneficiary when it sent a letter with the right to recovery agreement to Eric Knudson. The right to recovery agreement altered the terms of the Plan *ex post facto*. This action was impermissible. (J.A. 245-246.) The right to recovery agreement did not limit the lien to the amount received by the covered person for such medical treatment. (J.A. 77-78.)

On June 3, 1993, Janette Knudson sued Hyundai Motors of America and others in Superior Court for the County of Los Angeles, State of California ("Knudson I"). Great-West was notified of the lawsuit in 1993.

On March 26, 1997, Janette Knudson served Petitioners with Notice of the Application for Approval of a Conditional Settlement and for the Establishment of the Janette Knudson Special Needs Trust and to satisfy the amounts of the liens by Great-West and Medi-Cal.[5] (J.A. 232-236.) The application before the State Court included the Summary Plan Description and the right to recovery language. Respondent Janette Knudson requested an interpretation of the Summary Plan Description to determine the amount of the lien owed to Great-West. (J.A. 145-166, 112-138.) Petitioner had the right to intervene in State Court, pursuant to California Code of Civil Procedure § 387. Petitioners did not intervene or oppose the State Court but instead removed the action to District Court. (J.A. 167-169.)

On June 30, 1997, the District Court remanded the action entitled, *Great-West Life & Annuity Ins. Co. v. Knudson, et al.*, Case No. CV 97-2801 JMI (JGx) ("Knudson II"), advising Great-West that the State Court could fairly adjudicate Respondent Janette Knudson's lien obligations. (J.A. 171-175.)

On July 3, 1997, Respondent Janette Knudson again served both Great-West and Earth Systems with the Petition for an Order to Approve a Conditional Settlement Agreement, Order directing the net money to be paid to the Janette Knudson Special Needs Trust, as authorized by California Probate Code § 3601 including the determination of lien rights. The notice of hearing was set for July 23, 1997. (J.A. 233-234.)

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5. The parties have stipulated that service was proper for all of the hearings discussed herein. (J.A. 232-236.)

On July 8, 1997, Petitioners served Respondent Janette Knudson with its verified First Amended Complaint in this case, case no. CV 97-3745 JMI(JGx) ("Knudson III"), plus Petitioners' application for a temporary restraining order and other moving papers. (J.A. 87-95.) The temporary restraining order was denied on July 9, 1997. (J.A. 96-99.)

On July 23, 1997, the State Court reviewed the ERISA Plan, including the right to recovery language in the Plan and Great-West's lien claim of $411,157.11. The court evaluated the limited settlement funds available in relation to the proportion of the past medicals recovered, the present value of future medical expenses, ($2,593,900.00) the past loss of earnings, and the present value of the future loss of earnings ($819,829.00) as well as the loss of enjoyment of life for the single mother who is a quadriplegic. The Court approved Great-West's lien at $13,828.70. (J.A. 139-166.) The State Court adjudicated the issues finding that the settlement was fair given the complex and contested liability issues which caused Janette Knudson to accept a compromise settlement that only minimally compensated her for her catastrophic injuries. (J.A. 139-144.) The Court authorized the establishment of the Janette Knudson Special Needs Trust pursuant to California Probate Code § 3604. (J.A. 139-144.) The Special Needs Trust is an irrevocable trust.

On August 1, 1997, Knudson served the order both on Great-West and on Earth Systems. (J.A. 234.) Petitioners failed to appeal or move to set aside the Order. Pursuant to the Court order, Janette Knudson transmitted the funds to Great-West on August 21, 1997. (J.A. 235.) As ordered by the Court, Defendant Hyundai directly funded the Janette Knudson Special Needs Trust. (J.A. 235.)

Thereafter, discovery in the underlying District Court litigation ensued. On May 14, 1998, after discovery and after numerous motions were argued, the District Court granted Janette Knudson's cross-motion for summary judgment based upon the Court's interpretation of the Plan's right to recovery language. (J.A. 237-249.)

On May 18, 1998, the court entered the written order adopting the statement of uncontroverted facts and conclusions of law. (J.A. 210-230.) The District Court stated:

* * *

> An interpretation of a plan which imposes additional terms which clash with the terms of a plan is considered arbitrary and capricious. (Citation.) Mr. Brown's interpretation of the Plan clashes with the terms of the Plan. A reviewing Court should not defer to an interpretation of the Plan that is flawed. *Atwood v. Newmont Gold Co. Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995).

(J.A. 246.)

On August 7, 1998, Great-West appealed the granting of summary judgment and attorney fees to the Ninth Circuit.

The Ninth Circuit Court of Appeals affirmed and based its holding on other grounds which presents the issues that are now before this Court.

III. ARGUMENT

A. Janette Knudson's Interest In This Appeal.

Janette Knudson is a quadriplegic and single mother who has no funds. The recovery from the underlying case was distributed: (1) according to the terms of an ERISA Plan; (2) pursuant to the order of the State Court; and (3) pursuant to the judgment of the District Court. Janette Knudson received no funds, a special needs trust was properly established pursuant to California Probate Code § 3604 *et seq*. due to the compromise nature of the recovery. The recovery was a small percentage of the total damage suffered by Janette Knudson. (J.A. 139-160.)

B. There Was A Separate And Independent Basis For The District Court's Granting Of Summary Judgment In That The Plan Administrator's Interpretation Was Arbitrary And Capricious.

Summary judgment in favor of Janette Knudson was granted on the merits of the case. Therefore, independent of the subject matter jurisdiction question, Great-West was not entitled to ignore the terms of the Plan which were properly interpreted by both Superior Court and by the District Court.

Petitioners infer that the District Court in this case failed to accept subject matter jurisdiction over this ERISA case. They are wrong. The District Court granted summary judgment in favor of Respondent Janette Knudson based upon the merits of her case and upon its interpretation of the ERISA Plan. (J.A. 210-236.) Petitioners infer that Great-West could not have been a party to the State Court action. Again, Petitioners are wrong. California Code of Civil Procedure § 387 allows for intervention by any party having an interest in the litigation.

C. Public Policy And Equity Demands Avoiding Multiplicity Of Lawsuits.

Public policy must promote efficiency in litigation to avoid multiplicity of actions. Further, a plaintiff in any tort case must have the right to settle a lawsuit in a context that allows her to have full understanding of proceeds that will be forthcoming after deductions for attorney fees, liens, and costs.

Knudson's service of the petition to compromise invoked concurrent jurisdiction on State Court to hear the matter pursuant to 29 U.S.C. § 1132(a)(1)(B). Great-West and Earth Systems had notice of Knudson's intent to adjudicate her claim that any claimed reimbursement in excess of the lien limitation language was prohibited by the terms of the Plan. This petition was filed and served on two different occasions, both before removal to and after remand by the District Court, therefore, providing Petitioners two separate opportunities in which to appear in order to protect their reimbursement claim or lien interest under the terms of the Summary Plan Description. Great-West and Earth Systems failed to act on either occasion. Equitable principles which underpin Petitioner's argument fail under factual scrutiny.

In this case Knudson desired to fulfill her obligations to the ERISA Plan in a fair manner. Accepting Great-West's argument that only a federal court can hear claims of reimbursement is disastrous. This procedure will always require the multiplicity of lawsuits and such a holding would create uncertainty for a plaintiff. The uncertainty will undoubtedly promote more litigation, fewer settlements and finally, less reimbursement for ERISA plans.

D. Equitable Principles Require That Reimbursement To A Plan Be Based On A "Common Fund" Theory.

It is well settled under federal law with respect to personal injury cases involving Medicare that the "common fund" rule is followed. Great-West's suggestion that it is entitled to a full recovery of all expenditures is unsupportable in equity. The government when Medicare pays for hospitalization benefits for an individual injured by a tortfeasor shares in the cost of obtaining a recovery against the tortfeasor. 42 C.F.R. § 411.37(a)(1)(i)(ii). Similarly, in California Medi-Cal liens are reduced under the common fund theory pursuant to statute. Cal. Welf. & Inst. Code § 14124.71 *et seq.* (West. 2001)

The foregoing considerations make it imperative that this Court consider adopting a procedure in equity which provides the Plan the opportunity to resolve its claims in State Court utilizing federal law in the underlying personal injury action, and yet allows the ERISA beneficiary to be protected in an equitable manner in situations when a full recovery is not forthcoming.

Thus, the rule of law that under the equitable principles of ERISA should allow for reimbursement in a fair manner which discourages multiplicity of lawsuits and yet treats both ERISA plans and their beneficiaries fairly under a "common fund" theory.

E. Equitable Remedies Must Apply To Janette Knudson.

Due to the arguments previously advanced earlier in her Opposition to the Writ of Certiorari and in her Motion to Dismiss, Respondent Knudson respectfully defers to the Brief of Amicus Curiae by Invitation on the issues of "appropriate equitable relief" and "subject matter jurisdiction."

In the event that this Court affirms the legal theories on which Janette Knudson prevailed in District Court then directions to the Ninth Circuit are necessary. Therefore, Janette Knudson requests that this Court protect her welfare if it determines that the Ninth Circuit's reliance upon *FMC v. Owens*, 122 F.3d 1258 (9th Cir. 1997) is erroneous. In such an event Janette Knudson requests that:

a. This Court determines that the District Court had jurisdiction to grant her cross-motion for summary judgment and the relief it afforded her, including attorneys fees;

b. Great-West must be precluded from re-litigating the District Court's summary judgment order, findings of fact and conclusions of law since this Court has reviewed a procedural issue; and

c. No costs or fees be awarded against Janette Knudson on this appeal.

IV. CONCLUSION

Based on the foregoing, Respondent Janette Knudson requests that this Court affirm the ruling of the Ninth Circuit or alternatively remand this matter to the Ninth Circuit with specific instructions to approve the factual determinations of the District Court which were not reviewed by this Court.

Respectfully submitted,

JEFFREY S. POP
JEFFREY S. POP & ASSOCIATES
A LAW CORPORATION
Attorneys for Respondent
Janette Knudson
9107 Wilshire Boulevard
Suite 600
Beverly Hills, CA 90210
(310) 273-5462

GRANTED

(19)

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In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

REPLY BRIEF FOR PETITIONERS

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, D.C. 20007
(202) 965-8100

THOMAS H. LAWRENCE
JOHN M. RUSSELL
HALE HEADRICK DEWEY WOLF GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

DAVID C. ASPINWALL
GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
8515 East Orchard Road
Greenwood Village, Colorado 80111
(303) 737-3000

Counsel for Petitioners

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

27 pp

LIST OF PARTIES

The caption of the case in this Court contains the names of all the parties. Petitioner Great-West Life & Annuity Insurance Company has as a parent a publicly held company, Great-West Lifeco, Inc., which has as parent corporations Power Financial Corporation of Canada and Power Corporation of Canada, all of which are publicly traded on the Toronto Stock Exchange.

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SUMMARY OF ARGUMENT

The Court-Invited Amicus ("Amicus") asserts that an action seeking enforcement of an employee benefit plan provision obligating a person covered under such plan to reimburse the plan out of any recovery from a third party for medical expenses paid by the plan is not an action for "equitable relief" under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), as that term was interpreted by the Court in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). Instead, Amicus contends that such an action "seeks nothing but money due under an obligation to pay." Brief of Amicus Curiae at 18.[1] Such a money claim, Amicus argues, is not an "equitable" remedy even though it is being sought to specifically enforce an obligation under the terms of the Plan and to avoid unjust enrichment at the Plan's expense. "[A]llowing an injunction ***to pay money to substitute for damages***" the Amicus contends, "would simply reverse the congressional rejection of such remedies as established by *Mertens'* definitive construction of Section 502(a)(3)." *Id.* at 19 (emphasis supplied).

Moreover, even though Amicus does not dispute that a claim seeking the enforcement of a plan's reimbursement provision could be viewed as a claim for restitution based on unjust enrichment, and acknowledges that *Mertens* generally refers to restitution as a form of "equitable relief" authorized under § 502(a)(3), Amicus asserts that the type of restitutionary claim sought in this case is not equitable because "[i]t does not involve specific plan property . . . [and] the recovery amount claimed is not money that was actually obtained from the plan or the proceeds or profits of such money, let alone money

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[1] The Respondent in this case previously has informed the Court that she concurs with Petitioners' position that such relief is available under ERISA and would not contest that issue before the Court. February 2, 2001, letter from Respondent to the Court suggesting that writ was improvidently granted, at p. 3.

obtained by anyone's wrong or error." *Id.* at 18. These arguments are without merit for three reasons.

First, this Court held in *Bowen v. Massachusetts* that an action seeking to enforce an obligation to pay money is an action for "specific relief" and not one for "money damages." 487 U.S. 879, 893 (1988). *Mertens*, which unquestionably involved an attempt to recover compensatory money damages under ERISA § 502(a)(3), does not bar the injunction sought in this case under § 502(a)(3) to enforce an obligation under the provisions of a plan, merely because the obligation happens to involve the payment of money. As the *Bowen* majority favorably cited:

> Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies 'are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled.' D. Dobbs, Handbook on the Law of Remedies 135 (1973). Thus, while in many instances an award of money is an award of damages, 'occasionally a money award is also a [specific] remedy.' *Id.* **Courts frequently describe equitable actions for monetary relief under a contract in exactly those terms.**

487 U.S. at 895, quoting *Maryland Dept. of Human Resources v. Department of Health and Human Services*, 763 F.2d 1441, 1446 (D.C. Cir. 1985) (emphasis added).

Second, Amicus ignores the plain meaning of the language of ERISA § 502(a)(3)(A) which authorizes actions "***to enjoin any act or practice which violates . . . the terms of [a] plan,***" which is precisely the relief sought in the Complaint in this case. Regardless of whether or not Amicus's analysis of the historical distinctions between actions in law and actions in equity were correct under other circumstances, and, regardless of the difference between the minority and dissenting opinions in *Mertens* and *Bowen* regarding distinctions between "damages" and "specific relief" and "legal" and "equitable relief," the plain language of § 502(a)(3)(A) makes it

clear that an action to enjoin "***any practice***" which violates the terms of an ERISA plan is authorized under that provision regardless of whether or not the injunction involves the enforcement of an obligation to pay money. As the Court has recognized, if the language of an ERISA provision is clear, as § 502(a)(3)(A) is here, it need not immerse itself into common law generally or the common law of trusts in particular.

Third, *Mertens* refers to restitution as a type of equitable relief allowable under § 502(a)(3) without reference to the sorts of limitations which Amicus suggests are applicable. To the contrary, *Mertens* approvingly cites cases interpreting language in Title VII of the Civil Rights Act of 1964 analogous to the language of § 502(a)(3) as a reference point for construing the term "equitable relief." 508 U.S. at 255. Such cases uniformly hold monetary restitution, such as back pay, to be "equitable relief" regardless of the traceability or the source of such award. *See, e.g., United States v. Burke*, 504 U.S. 229 (1992).

Finally, Amicus argues that even if Petitioners' reimbursement claim is one for equitable relief under § 502(a)(3), it nevertheless is not for "appropriate" equitable relief under that section. This argument overlooks the fact that because Congress, pursuant to § 502(a)(3)(A), expressly authorized injunctive relief to enforce plan terms or to prevent violations of plan terms such as the reimbursement provision at issue, such relief by definition is "appropriate." This relief, moreover, relates to a central matter of plan administration and implicates ERISA's requirements that plans be administered and benefits be paid in accordance with plan documents. In ERISA's comprehensive scheme, Congress has already struck the balance between federal and state court relations and determined that federal courts are the exclusive forum for litigating claims for the relief provided under ERISA § 502. Accordingly, if the relief sought in this case is "equitable" within the meaning of § 502, it must *per se* be "appropriate."

Even if the Court were to determine that § 502(a)(3) does not provide for a reimbursement action based upon a plan's reimbursement provision, then ERISA's interest in a uniform system for determining rights and obligations under employee benefit plans should be found to give rise to an alternative action cognizable under the federal common law.

ARGUMENT

A. The Enforcement Of The Plan's Reimbursement Provision Constitutes "Equitable Relief"

1. The Enforcement of the Plan's Reimbursement Provision under ERISA § 502 is Consistent with this Court's Distinction Between "Money Damages" and "Specific Relief"

Amicus asserts that the enforcement of a plan reimbursement provision which requires the payment of money does not fall within the meaning of "equitable relief" under § 502(a)(3) of ERISA pursuant to the standards set forth by this Court in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). Quite the opposite is true.

In *Mertens*, this Court held that an action to recover losses to a plan allegedly resulting from an actuarial firm's failure to challenge the plan's actuarial assumptions, causing the plan to be underfunded, was "nothing other than compensatory damages – monetary relief for all losses [the] plan sustained as a result of the alleged breach of fiduciary duties." 508 U.S. at 255. In contrast with the compensatory damages unsuccessfully sought in *Mertens*, the Court interpreted "equitable relief" for purposes of § 502(a)(3) to mean "those categories of relief that were *typically* available in equity (***such as injunction, mandamus, and restitution, but not compensatory damages***)." *Id.* at 256 (emphasis supplied).

Unlike the relief sought under § 502 in *Mertens*, an action seeking the enforcement of a plan's reimbursement

provision, like the one at issue in this case, does not constitute an action for compensatory money damages, which is the only type of relief specifically excluded under § 502(a)(3) by the Court in that case. Rather, it constitutes an action for "specific relief" to prevent a violation of the terms of a plan. Such a distinction was clearly recognized by this Court in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), where the Court held that a suit by the State of Massachusetts which sought monetary reimbursement from the Federal Department of Health and Human Services for services performed by Massachusetts agencies (and purportedly reimbursable under Medicaid) constituted an action for "specific relief" rather than one for money damages. 487 U.S. at 893.

Amicus does not dispute that the Court held in *Bowen* that a suit seeking to enforce an obligation for the reimbursement of money was not an action for "money damages." Rather, he argues that *Bowen* did not turn on a distinction between "equitable" actions and other actions. Brief of Amicus Curiae at 29-30, citing *Department of the Army v. Blue Fox, Inc.*, 525 U.S. 255 (1999).[2] While it is true that the Court in *Bowen* was not required to resolve the issue of whether the action to enforce a monetary reimbursement obligation was an "equitable" action, this Court, other courts, and commentators have almost uniformly characterized "specific relief" as "equitable." In *Bowen*, for example, the Court observed:

> Our cases have long recognized the distinction between an action at law for damages – which are intended to provide a victim with monetary compensation for an injury to his person, prop-
> compensation for an injury to his person, property, or reputation – and an equitable action for

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[2] *Blue Fox* is inapposite here because it involved an attempt to enforce a lien which the Court characterized as "substitute relief" as distinguished from the "specific relief" sought in *Bowen*. *Bowen*, 487 U.S. at 893-895.

> specific relief – which may include an order providing the reinstatement of an employee with backpay, or for 'the recovery of specific property *or monies*, ejectment from land, or injunction either directing or restraining the defendant officer's actions.'

487 U.S. at 893 (emphasis in original) (quoting *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 688 (1949)). *See also* 487 U.S. at 895 ("Thus, while in many instances an award of money is an award of damages, '[o]ccasionally a money award is also a specie remedy.' [internal citation omitted] ***Courts frequently describe equitable actions for monetary relief under a contract in exactly those terms.***") (emphasis added) (quoting *Maryland Dept. of Human Resources v. Department of Health and Human Services*, 763 F.2d 1441 (D.C. Cir. 1985)); 3 Pomeroy's Equity Jurisprudence §§ 1400-1401, at 440-441 (1883) (noting that specific performance is an equitable remedy); 3 Dan B. Dobbs, Law of Remedies: Damages – Equity – Restitution § 12.8(1), at 191 (2d ed. 1993) ("The specific performance decree originated in the old equity courts and continues today to be thought of as an equitable remedy, . . . "). *Cf. Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999) (finding an action for the enforcement of a monetary reimbursement clause to be one for equitable relief); *Blue Cross and Blue Shield of Alabama v. Sanders*, 138 F.3d 1347 (11th Cir. 1998) (same).

As demonstrated below, however, one need not agree with the majority opinion in *Bowen*, or take exception with Amicus's analysis of formal common law distinctions between relief available in law or equity to resolve the issue before the Court in this case – whether § 502(a)(3) authorizes the enforcement of a provision of an employee benefit plan that happens to involve the payment of money – because reference to the plain language of § 502(a)(3)(A) is dispositive.

2. The Enforcement of the Plan's Reimbursement Provision is Consistent with the Language of ERISA § 502(a)(3)(A) Which Authorizes Actions "To Enjoin Any Act or Practice Which Violates . . . the Terms of [a] Plan"

Petitioners' action to enforce the Plan's reimbursement provision is consistent with the Court's distinction between "money damages" and "specific relief." More significantly, it is consistent with the plain language of ERISA § 502(a)(3)(A), which authorizes actions "***to enjoin any act or practice which violates . . . the terms of [a] plan . . . .***" There is no dispute that Petitioners' Complaint in this case expressly sought such an injunction. J.A. 81, 85. Amicus argues, however, that if merely seeking an "injunction" were enough to come within § 502(a)(3), then plaintiffs could circumvent the exclusion of money damages from the type of relief authorized under § 502(a)(3) by framing their demand as one for an injunction requiring defendants to pay the money claimed. Brief of Amicus Curiae at 33. This argument overlooks the fact that the injunction sought by Petitioners in this case is not a disguised claim for "money damages" as that term has been interpreted by the Court. Rather, it is a suit to recover money owed Petitioners under the reimbursement provision of a plan and which Respondents have failed to pay in violation of the terms of the Plan. This Court has characterized such relief as "specific relief" as distinguished from compensatory damages. *See Bowen*, 487 U.S. at 893-896.

The plain language of § 502(a)(3)(A) does not merely authorize actions to enjoin violations of a plan that do not involve the payment or retention of money. Rather, such language authorizes actions to "enjoin ***any act or practice*** which violates . . . the terms of [a] plan . . . . " ERISA § 502(a)(3)(A), 29 U.S.C. § 1132(a)(3)(A) (emphasis added). Given these clear words of the statute regarding the remedy under consideration, the Court should

decline Amicus's invitation to substitute arcane common law distinctions (which Petitioners dispute) for the unambiguously expressed intent of Congress, which is that plan fiduciaries may enforce or prevent violations of plan terms in a federal court action. *See Harris Trust and Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 254 (2000) ("We decline these suggestions to depart from the text of § 502(a)(3). In ERISA cases, '[a]s in any case of statutory construction, our analysis begins with the language of statute . . . And where the statutory language provides a clear answer, it ends there as well.' ").

Amicus concedes that "[b]y the act of accepting the benefits, a beneficiary generally becomes contractually bound to the clear terms on which they were offered" and that "[i]t is that obligation which forms the entire basis for the claim to money here." Brief of Amicus Curiae at 24.[3] Amicus, however, chooses to ignore that a primary objective of ERISA is the enforcement of ERISA plans in accordance with their terms, which is precisely what § 502(a)(3)(A) provides. *See, e.g., Gulf Life Insurance Company v. Arnold*, 809 F.2d 1520, 1523 (11th Cir. 1987) ("The purpose essential to section 1132(a)(3)(B) is to enforce the terms of [a] plan . . . "); *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997) ("A primary purpose of ERISA is to ensure the integrity and primacy of the written plans.").[4]

In contrast with *Mertens*, which involved a claim for compensatory damages sought for a violation of ERISA provisions addressing breach of fiduciary duty, an

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[3] Respondent has previously conceded that *she* could have brought an ERISA action seeking to resist enforcement of the Plan's reimbursement provision. *See* Petitioners' Opening Brief at 30 n.12. Congress should not be considered to have omitted from ERISA's comprehensive enforcement scheme federal court jurisdiction over a plan fiduciary's claim to enforce the same plan terms.

[4] *See also infra*, discussion of *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001) at p. 15.

alleged violation of a plan lies at the heart of this case, and the relief being sought is the simple enforcement of its terms. In distinguishing money damages from "appropriate equitable relief," the Court in *Mertens* was careful to note that it was not dealing with the very type of claim here at issue:

> We note at the outset that it is far from clear that, even if this provision does make money damages available, it makes them available for the actions at issue here. It does not, after all, authorize "appropriate equitable relief" at large, but only "appropriate equitable relief" for the purpose of "redress[ing any] violations or . . . enforc[ing] any provisions" of ERISA or an ERISA plan. ***No one suggests that any term of the Kaiser plan has been violated, nor would any be enforced by the requested judgment.***

Mertens, 508 U.S. at 253 (emphasis added). *Mertens* rejected a hypertechnical reliance upon the common law of trusts to construe the scope of relief under § 502(a)(3) as to a fiduciary breach claim (*id.* at 257-258), and Amicus has given no reason (for none exists) for adopting such an approach as to the enforcement of plan terms.[5]

If the property owed by the Respondent under the Plan reimbursement provision at issue here involved something other than money, it would be evident that an action for injunction to recover such property was authorized under § 502(a)(3)(A). The fact that in the present case, the property, the withholding of which by the Respondent is alleged to violate the terms of the Plan, is money, should not transform the characterization of the nature of the relief sought, as Judge Bork held in *Maryland Dept. of Human Resources* (which case, in turn, was relied upon by this Court in *Bowen*). *See* 487 U.S. at 895

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[5] Even with respect to the contours of ERISA fiduciary duty issues, this Court will "recognize, however, that trust law does not tell the entire story." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

(citing 763 F.2d at 1446). Under either circumstance the relief being sought is to "enjoin [an] act or practice which violates . . . the terms of [a] plan." *See, e.g., Porter v. Warner Holding Co.*, 328 U.S. 395, 399-403 (1946) (opining that an order for the recovery and restitution of excessive rents falls under a court's equity jurisdiction under § 205(a) of the Emergency Price Control Act to issue orders to *enjoin acts or practices that constitute or will constitute violations of the act, or to enforce compliance with the act*).

3. The Enforcement of the Plan's Reimbursement Provision is also Consistent with this Court's Characterization of Restitutionary Relief

Amicus does not dispute that the Court characterized "restitution" in *Mertens* as an example of the type of "equitable relief" authorized in a suit under § 502(a)(3)[6], and, subsequently, in *Harris Trust*, authorized a suit under § 502(a)(3) to recover monetary restitutionary relief from a nonfiduciary party-in-interest who participated in a transaction prohibited by ERISA § 406(a), 29 U.S.C. § 1106(a), although such party had not breached any duty to the plan.[7] Moreover, contrary to the position of the Ninth Circuit in *Owens* that restitution involving the payment of money is only available as "equitable relief" when the money in question constitutes "ill-gotten" assets obtained "by any fraud or wrong-doing,"[8] Amicus acknowledges that "***the defendant need not have engaged in wrongdoing to be subject to equitable remedies for restitution, even where money was at issue, a point established in Harris Trust and not in dispute.***" Brief of Amicus Curiae at 28-29 (emphasis supplied).

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[6] *Mertens*, 508 U.S. at 256.

[7] *Harris Trust and Savings v. Salomon Smith Barney Inc.*, 530 U.S. 238, 249-253 (2000).

[8] *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997).

Notwithstanding these concessions, Amicus argues that a suit such as the present one which seeks the reimbursement of funds allegedly retained in violation of the terms of the Plan is not the sort of restitutionary relief available under § 502(a)(3) because the money sought from Respondents is not specifically traceable to the Plan[9] and was not transferred to Respondents by a wrongdoer. Brief of Amicus Curiae at 22-29. "Money not specifically traceable to wrongly received funds", Amicus argues, falls outside of the type of restitutionary relief available in equity as distinguished from restitutionary relief available in law (*e.g.*, assumpsit). *Id.* at 27. Nothing, however, in the language or objectives of ERISA or the decisions of this Court suggests that § 502(a)(3) is intended to draw this highly formal and restrictive distinction. To the contrary, as Amicus correctly notes for other purposes (*id.* at 21), *Mertens* explicitly rejected defining "equitable relief" for purposes of § 502(a)(3) with reference to whether or not a particular form of relief such as restitution was available in an equity court or a court of law. 508 U.S. at 257-258.

That this Court intends the scope of the restitutionary relief available under § 502(a)(3) to be more expansive than suggested by Amicus is evident in the Court's prior decisions. In *Mertens*, the Court analogized interpretation of the term "appropriate equitable relief" under § 502(a)(3) to the interpretation of similar language in Title VII of the Civil Rights Act of 1964 (before its 1991 amendment). 508 U.S. at 255. In this regard, decisions of this Court and the lower courts uniformly recognize the award of back pay in a Title VII case as equitable relief without regard to the specific traceability or derivation of the funds awarded. *See, e.g., United States v. Burke*, 504 U.S. 229, 238 (1992); *Wilson v. Daimler Chrysler Corp.*, 236

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[9] Assuming *arguendo* that traceability were required for restitutionary relief, it is clearly not required for an injunction or specific performance.

F.3d 827, 830 (7th Cir. 2001); *Cox v. Phelps Dodge Corp.*, 43 F.3d 1345, 1347 (10th Cir. 1994).[10]

Likewise, Amicus spends pages suggesting that the relief Petitioners seek is not truly "equitable relief" or "specific relief" because Petitioners are not seeking the return of the "specific property" paid by the Plan or possessed by the Respondent. However, Amicus's argument is flawed to the extent it focuses on anything other than the *nature* of the relief sought – the focus of this Court's attention in *Bowen*. This Court has already made clear that specific relief is that which attempts to give to the plaintiff that to which it was already entitled. *Bowen*, 487 U.S. at 895, citing *Maryland Dept. of Human Resources*, 763 F.2d at 1446. As the *nature* of the relief sought is the primary focus, whether the defendant is in possession of the precise property is not dispositive. *See, e.g., America's Community Bankers v. Federal Deposit Ins. Corp.*, 200 F.3d 822, 829-830 (D.C. Cir. 2000) (rejecting defendant's claim that the relief sought by plaintiffs constituted money damages, as distinguished from specific relief, notwithstanding the fact that the party from whom the relief was sought was no longer in possession of the specific funds at issue: "That the FDIC no longer possesses the *precise funds* collected is not determinative of this analysis.") (emphasis added).

Finally, that monetary restitution is generally intended to be available as a remedy to prevent unjust enrichment at the expense of a plan and its participants, regardless of the traceability or source of the funds at issue, is confirmed in the Court's favorable citation in

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[10] In a like vein, all federal courts of appeals to have addressed the issue have concluded that a participant's claim for monetary relief under ERISA § 502(a)(1)(B) is an equitable action as to which no right to jury trial exists. *See Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156 (10th Cir. 1998) and *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251 (2d Cir. 1996).

Harris Trust of the following explication of restitution in an earlier case:

> Whenever the legal title to property is obtained through means or under circumstances 'which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same, although he may never, perhaps, have had any legal estate therein[.]

Harris Trust, 530 U.S. at 250-251 (quoting *Moore v. Crawford*, 130 U.S. 122, 128 (1899) (quoting 2 Pomeroy, Equity Jurisprudence § 1053, pp. 628-629 (1886))). *See also Adams v. Cyprus Amax Minerals Co.*, 149 F.3d at 1156, 1162 (1998) (noting that "[b]y definition, an action for restitution has for its primary purpose the 'taking from the defendant and restoring to the plaintiff something to which the plaintiff is entitled' " and finding that the "payment of monetary benefits allegedly wrongly held" fits this definition) (quoting Restatement (First) of Restitution Pt. I, Ch. 8, To. 2, Intro. Note (1936 Main Vol.)). It is undeniably "unconscientious" for Respondents to fail to honor their obligations under the terms of the Plan's reimbursement provision.

B. The Enforcement Of Plan Terms Is "Appropriate" Relief Under ERISA § 502(a)(3)

1. The Petitioners' Reimbursement Claim is "Appropriate" by the Very Terms of the Statute

ERISA § 502(a)(3)(A) provides as a remedy a civil action "to enjoin any act or practice which violates . . . the terms of the plan, . . . " Congress thus has clearly stated that such relief as sought here is proper. Amicus's argument that a reimbursement action is, even if equitable, nevertheless not "appropriate" equitable relief (Brief of Amicus Curiae at 39, *et seq.*), relies upon ERISA

§ 502(a)(3)(B), which ***also*** allows a civil action "to obtain *other* appropriate equitable relief (i) to redress such violations or (ii) to enforce . . . the terms of the plan . . . ." Congress' use of the adjective "other" in subsection (a)(3)(B) confirms that the specific equitable relief of the type provided by (a)(3)(A), is, by definition, "appropriate equitable relief." A contrary conclusion would result in, at best, § 502(a)(3)(A) being accorded a strained meaning, if not rendered entirely meaningless. *Rose v. Lundy*, 455 U.S. 509, 517-518 (1982) (courts should endeavor to give meaning to statutory language when possible) (citing *United States v. Sisson*, 399 U.S. 267, 297-298 (1970)).

Moreover, Amicus asks the Court, for purposes of its argument that the relief sought in this case is not "appropriate," to assume that it is, in fact, "equitable." Under that assumption (which is, in fact, correct), any conclusion that such "equitable relief" was not "appropriate" would be totally inconsistent with the principle well established by this Court that ERISA is the "exclusive" vehicle for obtaining any relief available through § 502. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-65 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990). If the relief sought in this case to enforce the terms of an ERISA plan is "equitable" and is not available under any provision of § 502, other than § 502(a)(3), consistent with the Court's recognition of the exclusivity of § 502 for enforcing relief available thereunder, such relief must be regarded as "appropriate" *per se*.

2. In Any Event, the Enforcement of a Plan Reimbursement Provision is an Appropriate Remedy Consistent with ERISA's Purposes

Amicus asserts that allowing Petitioners to pursue their reimbursement claim in federal court would conflict with ERISA policy, because of increased litigation expenses, and create potential for friction between federal and state courts. (*See* Brief of Amicus Curiae at 41, *et*

seq.). The short answer is that since Congress has clearly provided for the relief Petitioners seek, the courts need not "adjust the balance between . . . competing goals that the text adopted by Congress has struck." *Mertens*, 508 U.S. at 263. In *Varity*, a situation which, unlike here, *required* this Court to fashion "appropriate" equitable relief, the Court instructed courts to "respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others.' " 516 U.S. at 515, citing *Pilot Life Ins. Co.*, 481 U.S. at 54.

Evidence of Congressional intent supportive of a reimbursement action grounded in the enforcement of plan terms can be found throughout ERISA's "comprehensive and reticulated" scheme. *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980). The Petitioners' reimbursement claim, like the state law which the Court found preempted in *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327-1328 (2001), "implicates an area of core ERISA concern," that being ERISA's commands that (i) a plan " 'specify the basis on which payments are made to and from the plan,' § 1102(4)," and (ii) the fiduciary shall administer the plan " 'in accordance with the documents and instruments governing the plan,' § 1104(a)(1)(D)[.]" (internal citations omitted). Indeed, the Court called the payment of benefits "a central matter of plan administration." *Id.* at 1328. Eliminating a remedy for reimbursement clearly provided under the terms of an ERISA plan would, no less than the state statute in *Egelhoff*, "directly conflict[ ] with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents." *Id.* at 1329.[11] Congress

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[11] The existence of a remedy under § 502(a)(3) for specific enforcement of a plan reimbursement provision finds an analog in a plan fiduciary's duty to collect delinquent contributions an employer is obligated by plan terms to make to a multiemployer plan, 29 U.S.C. § 1145. *See Moore v. Am. Fed. of Tel. & Radio Artists*, 216 F.3d 1236 (11th Cir. 2000).

indisputably imposed these obligations upon the fiduciaries of the Petitioners' plan, with the concomitant obligation that they enforce such terms. Nothing in ERISA suggests that Congress meant to deprive federal courts of jurisdiction to hear such claims.[12]

Recognizing that the Ninth Circuit's decision would subject plans to an intolerable, non-uniform system of state regulation, at odds with Congressional purposes and with this Court's decision in *FMC v. Holliday*,[13] if not

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[12] In any event, the scenario of "harmful duplicative state and federal court litigation" (Brief of Amicus at 41) that Amicus posits is unsupported. In federal courts (outside the Ninth Circuit) where reimbursement claims are authorized, no such maelstrom has developed. *See Lyons v. Philip Morris Inc.*, 225 F.3d 909, 913 (8th Cir. 2000) ("We do not share the . . . concern that *Southern Council* and this decision [holding that a claim for specific performance of plan's subrogation clause falls within § 502(a)(3)'s exclusive jurisdiction] will 'federalize' personal-injury litigation involving ERISA beneficiaries."). Indeed, the unified front of employers/plan sponsors, insurers, and administrators, as well as the United States, as *amici* in support of Petitioners, offers convincing proof that plans benefit, not suffer, from the availability of such a remedy. Their conviction has been born out of the actual experience of benefit plans in litigating reimbursement claims in federal and state courts. For example, in most states a reimbursement claim would be a contingent, totally separate action (not unlike that for contribution or indemnity) that does not even ripen until after resolution of the underlying tort claim. *See Unisys Medical Plan v. Timm*, 98 F.3d 971, 973 (7th Cir. 1996). Thus, an entirely separate lawsuit is generally required, whether in state or federal court.

[13] In *FMC Corp. v. Holliday*, this Court specifically recognized that relegating a plan's recoupment rights to a "patchwork scheme of [state] regulation would introduce considerable inefficiencies in benefit program operation, . . . " 498 U.S. 52, 60 (1990) (internal citation and quotation marks omitted) (Pennsylvania's anti-subrogation law which prohibited plans from being structured in a manner requiring

with no remedy at all, *see Jefferson-Pilot Life Ins. Co. v. Krafka*.[14] Amicus asserts that such a problem could be avoided by state courts applying "relevant federal law principles." Brief of Amicus Curiae at 47-49. In other words, this Court should close the doors of federal courts to such actions but declare that state courts should develop a federal common law of ERISA to be applied in state courts. To accomplish this, which Amicus says would leave reimbursement claims governed by the same uniform federal substantive law, Amicus argues that state court procedures and jurisdiction (called "mechanisms" by Amicus) should not be preempted. *Id.* The issue in this case, however, neither asks nor requires the Court to address any issue of ERISA preemption. Moreover, Amicus does not (and cannot) offer any explanation as to how to assure that state courts uniformly adopt federal substantive law in the absence of federal jurisdiction to interpret and enforce plan reimbursement provisions.

In any event, assuming, as Amicus's argument on this point does, that Petitioners have a claim for reimbursement governed by federal law, Congress could not have been more clear on where a claim under § 502(a)(3) must be litigated – federal court jurisdiction under § 502(e) is exclusive. Moreover, the Court in *FMC v. Holliday* clearly recognized the inefficiencies of applying a "patchwork scheme of [state] regulation . . . " to plan reimbursement and subrogation rights. 498 U.S. at 60. Consequently, as held in *Jefferson-Pilot v. Krafka*, a claim in state court to

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reimbursement in the event of recovery from a third party found preempted).

[14] *Jefferson-Pilot Life Ins. Co. v. Krafka* was an action alleging violation of the terms of an employee benefit plan and brought to enforce the reimbursement provision of the policy. The *Jefferson-Pilot* court ruled that the plaintiff's state common law claims "relate to" the plan and were therefore preempted. 57 Cal. Rptr. 2d 723, 726 (Cal. Ct. App. 1996).

enforce a plan reimbursement provision should be pre-empted. Thus, Amicus's argument would have the effect of leaving an employee benefit plan without a remedy to enforce the plan's terms, a result inconsistent with this Court's recognition of § 502(a)(3) as a "safety net" to provide relief that is consistent with ERISA's objectives but that § 502 does not elsewhere provide. *See Varity v. Howe*, 516 U.S. 489, 512 (1996).

Furthermore, federal courts are, as Congress intended, and as this Court and the federal courts of appeals have recognized, the natural place to develop those federal rules of plan interpretation, including, where appropriate, federal common law. *Provident Life & Accident Insurance Co. v. Waller*, 906 F.2d 985, 990 (4th Cir. 1990) ("[B]oth the Supreme Court and this circuit recently gave express authorization for federal courts to develop a federal common law of rights and obligations under ERISA-regulated plans.") (citing *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989)) (internal quotation marks omitted). Indeed, outside the Ninth Circuit this is happening with dispatch.

Accordingly, even in the event Congress is found to have left to the courts the task of determining, on a case-by-case basis, whether an action under ERISA between a plan fiduciary and participant seeking to enforce plan terms is "appropriate," the Petitioners' reimbursement action most certainly is.

C. Federal Common Law Provides An Alternative Remedy For Reimbursement Even If ERISA § 502(a)(3) Does Not

Aside from disputing the ability of federal courts to recognize federal common law remedies to fill interstices in ERISA's express remedial scheme where appropriate and necessary to effectuate the purpose of ERISA, Amicus asserts two procedural bars to Petitioners' alternative argument that federal common law provides a

remedy for reimbursement of expenses that Petitioners have already paid.

First, Amicus states that the issue on which this Court granted certiorari is whether the term "appropriate equitable relief" under § 502(a)(3) is broad enough to encompass a reimbursement claim by a plan fiduciary against a plan participant for medical expenses that the participant recovers from a third-party tortfeasor. Brief of Amicus Curiae at 39. The issue on which the Court granted certiorari was not so confined. Rather, Petitioners asked the Court to consider whether the Ninth Circuit erred in holding "that federal courts lack subject matter jurisdiction over actions brought by ERISA plan fiduciaries to enforce reimbursement provisions." Petition for Certiorari, Question 1.

Second, Amicus argues that this issue was not raised in the Ninth Circuit and thus cannot be addressed by this Court. Brief of Amicus Curiae at 39. Again, however, Petitioners' arguments in the Ninth Circuit were not confined to remedies available under § 502(a)(3). Rather, Petitioners' opening brief noted the applicability of federal law to mold appropriate remedies under ERISA. (Appellants' Brief of Dec. 8, 1998 at 17-19). Ninth Circuit precedent, however, precluded further consideration because the court adhered to circuit precedent that it lacked subject matter jurisdiction to entertain the claim. J.A. 253. Raising the issue of federal common law providing a remedy under ERISA would have been futile, and the law does not require the performance of a futile act. *See Ohio v. Roberts*, 448 U.S. 56, 74 (1980).

Accordingly, this Court, in determining that a plan's claim for reimbursement well serves ERISA's purposes, may find the remedy alternatively available under § 502(a)(3) or the federal common law, either of which claims can properly be brought in federal court.

CONCLUSION

Wherefore, for the additional foregoing reasons, Petitioners respectfully ask that this Honorable Court reverse the judgment of the Ninth Circuit and remand the matter for further proceedings in which the court shall determine the amount of reimbursement recovery that Petitioners are entitled to under the Plan reimbursement provision.

Respectfully submitted,

JAMES F. JORDEN
Counsel of Record
WALDEMAR J. PFLEPSEN, JR.
STEPHEN H. GOLDBERG
JORDEN BURT LLP
1025 Thomas Jefferson Street, N.W.
Suite 400 East
Washington, DC 20007
(202) 965-8100

THOMAS H. LAWRENCE
JOHN M. RUSSELL
HALE HEADRICK DEWEY WOLF
GOLWEN THORNTON & CHANCE
1727 Kirby Parkway
Suite 150
Memphis, Tennessee 38120
(901) 888-4006

DAVID C. ASPINWALL
GREAT-WEST LIFE & ANNUITY
INSURANCE COMPANY
8515 East Orchard Road
Greenwood Village, Colorado 80111
(303) 737-3000

Counsel for Petitioners Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc.

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No. 99-1786

In the Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, ET AL., PETITIONERS

v.

JANETTE KNUDSON AND ERIC KNUDSON

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

BARBARA D. UNDERWOOD
Acting Solicitor General
Counsel of Record
EDWIN S. KNEEDLER
Deputy Solicitor General
BETH S. BRINKMANN
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

JUDITH E. KRAMER
Acting Solicitor of Labor
ALLEN H. FELDMAN
Associate Solicitor
NATHANIEL L. SPILLER
Deputy Assistant Solicitor
GARY K. STEARMAN
Attorney
Department of Labor
Washington, D.C. 20210

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QUESTION PRESENTED

Whether a civil action brought under Section 502(a)(3) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1132(a)(3), to redress a violation of, or to enforce, a term of a plan that requires a plan participant or beneficiary to reimburse the plan for medical expenses paid by the plan if the participant or beneficiary receives a recovery from a third-party tortfeasor, constitutes an action for "appropriate equitable relief" authorized by Section 502(a)(3).

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4 J. Pomeroy, *Equity Jurisprudence* (5th ed. 1941) 23-24, 26, 27
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5 A. Scott & W. Fratcher, *Scott on Trusts* (4th ed. 1989 & Supp. 2000) 28, 29
3A A. Scott & W. Fratcher, *The Law of Trusts* (4th ed. 1988) 18
1 J. Story, *Equity Jurisprudence* (14th ed. 1918) 20

In the Supreme Court of the United States

No. 99-1786

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, ET AL., PETITIONERS

v.

JANETTE KNUDSON AND ERIC KNUDSON

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTERESTS OF THE UNITED STATES

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA). 29 U.S.C. 1132(a)(3), authorizes an ERISA plan participant, beneficiary, or fiduciary to bring a civil action to obtain "appropriate equitable relief" to redress violations of, and to enforce, both the terms of the plan and Title I of ERISA, 29 U.S.C. 1101-1169 (1994 & Supp. V 1999). This suit was filed by an employee benefit plan, its administrator (as a fiduciary of the plan), and its insurer to enforce a term of the plan that requires a participant or beneficiary to reimburse the plan for medical expenses out of any funds recovered by the participant or beneficiary from a third-party tortfeasor. The question presented is whether the relief sought by the plan to obtain reimbursement constitutes equitable relief within the meaning of Section 502(a)(3).

The Secretary of Labor is authorized under Section 502(a)(5) of ERISA, 29 U.S.C. 1132(a)(5), to bring civil actions to obtain "appropriate equitable relief" to redress violations of, and to enforce, Title I of ERISA. Accordingly, the Court's determination of what constitutes "appropriate equitable relief" may affect not only the scope of private civil actions under Section 502(a)(3) to enforce Title I, which are a necessary complement to actions by the Secretary, but also the scope of the Secretary's own authority to enforce Title I of ERISA.

STATEMENT

1. Petitioner Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. (the plan), is a medical and hospital benefits plan that qualifies as an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* Pet. App. A2, C2. Petitioner Earth Systems, Inc. (Earth Systems), is the sponsor and administrator of the plan. J.A. 24-25, 89. Petitioner Great-West Life & Annuity Insurance Company (Great-West) is the stop-loss insurer for the plan and the assignee of the plan for purposes of obtaining reimbursement. Pet. App. A2, C2.[1]

Respondent Janette Knudson was seriously injured in an automobile accident on June 10, 1992. Pet. App. A2. At the time of the accident, she was covered by the plan as an eligible dependent because she was the spouse of respondent Eric Knudson, who was an employee of a wholly-owned

[1] The district court explained that "[t]he Plan had a 'Stop-Loss' insurance agreement with Great-West, whereby the Plan would pay any benefits up to $75,000 and Great-West would pay any excess amount. Additionally, the stop-loss allowed Great-West the right to recover first from amounts paid to the Plan by third parties. The stop-loss limits the Plan's risk of dissipating all of its assets for a single member." Pet. App. C2.

subsidiary of petitioner Earth Systems and a participant in the plan. *Id.* at A2, C2.

2. The summary plan description (SPD) for the plan[2] provided that, in the event a "third party may be liable or legally responsible for expenses incurred by a Covered Person for: an illness; or a sickness; or a bodily injury," the plan would pay the covered expenses, but would "have the right to recover from the Covered Person any payment for benefits paid for treatment of such [l]oss * * * which the Covered Person is entitled to receive from the third party." J.A. 58. The SPD further provided that the plan would "have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person receives" from the third party or the third party's insurer. *Ibid.* The lien was not to exceed "the amount of benefits paid" by the plan for the medical treatment or "the amount received by the Covered Person for such medical treatment from the third party." J.A. 59. The SPD also set forth certain conditions pertaining to the plan's right of recovery. First, it stated that the covered person must "cooperate fully" with the plan in asserting its right to recover. *Ibid.* Second, the SPD specified that, if the covered person received a recovery from a third party but failed to reimburse the plan, the person would be personally liable to the extent of the recovery from the third party up to the amount of the plan's

[2] Pursuant to Sections 101(a)(1) and 102(a)(1) of ERISA, 29 U.S.C. 1021(a)(1) and 1022(a)(1) (1994 & Supp. V 1999), a SPD must be furnished to all participants and beneficiaries of the plan. It must include specific information about the plan, including eligibility requirements and procedures for claim submissions. 29 U.S.C. 1022(a)(1) (1994 & Supp. V 1999). It must be "written in a manner calculated to be understood by the average plan participant" and "must be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. 1022(a)(1) (1994 & Supp. V 1999). See *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 83-84 (1995).

first lien. *Ibid.* Third, the SPD provided that, before the plan paid for treatment, it "may require the Covered Person to provide all information and sign and return all documents necessary to exercise [its] rights [of recovery] under this provision." *Ibid.*

Pursuant to those terms of the plan, petitioner Great-West, on behalf of the plan, notified respondent Eric Knudson on August 19, 1992, of the plan's entitlement to full reimbursement for any expenses paid on Janette Knudson's behalf, if any settlement or judgment was received from a court. J.A. 71-72. On September 30, 1992, Great-West wrote a similar letter to Janette Knudson. J.A. 75-76. Great-West explained that it was investigating the plan's possibilities for recovering from third parties, and it informed Janette Knudson of the plan's first lien right of recovery to any sums she received in settlement or in satisfaction of a judgment as a result of the accident. J.A. 75. Great-West also requested, in conformity with the plan, that she sign a right-of-recovery agreement. J.A. 75-76. Great-West's letter stated that any attorney representing Knudson should be given the correspondence and that any "[s]ettlement of this matter in contravention" of the terms in the letter "does not extinguish the Plan's rights in this matter or reduce its legal options." J.A. 76.

On October 20, 1992, respondent Eric Knudson signed the right-of-recovery agreement. See J.A. 77-78. In that agreement, he acknowledged that as a participant in the plan he had made a claim for covered medical benefits for his wife's injuries, and he requested that benefits be paid by the plan at that time "without the necessity of awaiting final determination of responsibility and with the understanding that no benefits may be payable and that another party or insurer may be liable for like benefits for which they will make payments." J.A. 77. Eric Knudson also agreed that the plan may be subrogated to any rights he or his dependent may

have to benefits from the other party; agreed to transfer to the plan any right he or his dependents may have to take legal action against the other party; and acknowledged that, under the terms of the plan, the plan may obtain reimbursement from him of any payment of benefits for which he or his dependents may be entitled to recover from a third party. J.A. 77-78. Eric Knudson further acknowledged that the plan "shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise"; that "[s]aid first lien shall be for the amount of medical and hospital benefits paid by the Plan"; and that he would be personally liable to the plan "to the extent of such recovery up to the amount of its first lien." J.A. 78. Finally, Eric Knudson agreed "to cooperate fully with the Plan in asserting its rights to recover." *Ibid.*

The plan paid benefits on behalf of Janette Knudson in the form of medical expenses totaling $411,157.11. Pet. App. A2.

3. In 1993, respondents filed suit in state court against the manufacturer of the automobile that Janette Knudson was driving when she was injured and against others allegedly responsible for the accident. Pet. App. A2, B1, C2. The parties ultimately settled the case for $650,000. By orders dated July 23, 1997, and August 1, 1997, the state court approved the settlement and resolved the status of various competing liens against the settlement. *Id.* at A2, C3-C4.[3] The settlement allocated five percent of the award, or $13,828.70, to past medical expenses. *Id.* at A2, C3. Respon-

[3] Respondents did not make petitioners parties to the suit in state court, Pet. App. B2, C2-C3, and petitioners did not attempt to intervene in that action, *id.* at C2. Nevertheless, on April 21, 1997, petitioners removed the state-court action to federal court before the settlement was approved by the state court. *Id.* at B2, C3. On June 27, 1997, the district court remanded the case to the state court. It held that because petitioners were not parties to the state-court action, they had no right of removal under 28 U.S.C. 1441. Pet. App. B1-B4, C3.

dents tendered a check in that amount to petitioners, who rejected the payment because in their view the plan was entitled to payment in full of the $411,157.11 in medical expenses that it had paid on behalf of respondents. *Id.* at A2-A3, C3-C4. Petitioners requested that respondents' attorney segregate the settlement funds pending the outcome of the instant suit in federal court, but respondents' attorney declined because the monies had gone directly from the automobile manufacturer to a trust established for Janette Knudson. *Id.* at C4.

4. a. Meanwhile, on May 19, 1997, petitioner Great-West had filed the instant action under Section 502(a)(3) of ERISA, 29 U.S.C. 1132(a)(3), to enforce the reimbursement provision of the plan through equitable and declaratory relief. J.A. 81-86. On July 3, 1997, Great-West, now joined by petitioners Earth Systems and the plan, filed a first amended complaint (see J.A. 87-95) requesting injunctive relief to prevent respondents from violating the plan by refusing to agree to reimburse it; to enforce the terms of the plan by requiring respondents to make reimbursement in the amount of $411,157.11 out of any proceeds recovered from third parties; and to prevent respondents from disposing of any funds received pursuant to a settlement because respondents had failed to honor petitioners' subrogation rights under the plan. J.A. 92-94. Petitioners also requested a declaration that respondents are required to reimburse the plan $411,157.11 out of any proceeds they recover from third parties, J.A. 93, a temporary restraining order to prevent respondents from seeking state-court approval of the settlement, *ibid.*, and "any other relief to which [the plan] is entitled," as well as attorney's fees. J.A. 95.[4]

[4] On July 9, 1997, the district court denied petitioners' request for a temporary restraining order. J.A. 96-99.

b. On May 14, 1998, the district court, ruling on cross-motions for summary judgment, entered judgment for respondents. Pet. App. C1-C12. The district court held that petitioners' rights under the plan were limited to the portion of the state-court settlement that was attributed by the state court to past medical expenses. *Id.* at C10.[5] The court rejected as arbitrary and capricious the plan administrator's interpretation of the plan to allow petitioners to be "reimbursed 100% of any third party recovery," because the court interpreted the plan to limit reimbursement to the lesser of "the amount of benefits paid out" by the plan ($411,157.11) *or* "the amount received from a third party for medical treatment," which the court understood here to be "the portion of the $650,000 [settlement] that is attributable to medical expenses." *Id.* at C9-C10.[6] The court held that because

[5] The district court rejected petitioners' argument that the state court lacked subject matter jurisdiction to determine the plan's lien rights. Pet. App. C5-C7. The district court held that the state court had concurrent jurisdiction under Section 502(a)(1)(B) and (e)(1) of ERISA, 29 U.S.C. 1132(a)(1)(B) and (e)(1), because "[t]he state court action to determine the status of liens on Janette Knudson's recovery is an action to enforce her rights under the terms of the * * * Plan." Pet. App. C6. If this Court reverses the court of appeals' holding that petitioners have no cause of action under Section 502(a)(3) of ERISA, the court of appeals may consider on remand whether the district court correctly held that the state court had jurisdiction to determine the plan's lien rights and whether petitioners could in any event be bound by the state court's determination of that issue even though they were not parties to the state-court action. See *Martin* v. *Wilks*, 490 U.S. 755, 762 & n.2 (1989) ("A judgment or decree among parties to a lawsuit resolves issues as among them, but it does not conclude the rights of strangers to those proceedings," except in certain limited circumstances.).

[6] The district court disregarded the right-of-recovery agreement signed by respondent Eric Knudson because, in the court's view, that agreement misstated the terms and obligations of the plan, lacked consideration, and deviated from the plan without a formal plan amendment. Pet. App. C8-C9. In particular, the court noted that although the agreement extended reimbursement to "'any' third party recovery," *id.* at C8,

the state court concluded that five percent of the settlement is attributed to petitioners' lien, petitioners' right of recovery in this action is limited to that amount.

5. a. The court of appeals affirmed the district court's judgment, but on different grounds. Pet. App. A2-A4. The court explained that Section 502(a)(3) of ERISA authorizes only an action for equitable relief, and that, in *FMC Medical Plan* v. *Owens*, 122 F.3d 1258 (9th Cir. 1997), it had held that "reimbursement of payments made to a beneficiary of an insurance plan by a third party, which [petitioners] seek here, is not equitable relief within the meaning of § 1132(a)(3)." Pet. App. A3-A4.[7] The court of appeals rejected petitioners' argument that *Owens* was wrongly decided and declined petitioners' request for en banc review, noting that it had recently reaffirmed the *Owens* holding in *Reynolds Metals Co.* v. *Ellis*, 202 F.3d 1246 (9th Cir.), cert. dismissed, 121 S. Ct. 674 (2000). Pet. App. A4.

b. The *Owens* decision, which the panel in this case felt bound to follow, held that under *Mertens* v. *Hewitt Associates*, 508 U.S. 248 (1993), the term "equitable relief" must be given a "narrow construction" for purposes of Section 502(a)(3) of ERISA, see 122 F.3d at 1262, and relief is limited to "injunction, mandamus, and restitution," *id.* at 1260-1261. The Ninth Circuit concluded in *Owens* that the complaint in that case—which sought reimbursement out of a partici-

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the plan itself, in the court's view, limited reimbursement to "the amount received from a third party for medical treatment," *id.* at C10.

[7] The court noted that the *Owens* panel had ordered dismissal for lack of subject matter jurisdiction, while in *Cement Masons Health & Welfare Trust Fund* v. *Stone*, 197 F.3d 1003, 1008 (9th Cir. 1999), petition for cert. pending, No. 99-1403, the panel ordered dismissal of the same type of claim on the merits, Pet. App. A4—*i.e.*, for failure to state a claim on which relief could be granted. For purposes of this case, the panel here noted, in evaluating the substantive holding of *Owens*, "the dismissal could be based either on lack of subject matter jurisdiction or on the merits." *Id.* at A4 n.5.

pant's third-party recovery for benefits paid by the plan—did not purport to seek either an injunction or mandamus. The court also concluded that restitution was not available because, in its view, *Mertens* holds that restitution consists only of the return of "ill-gotten" assets or profits taken from a plan, *id.* at 1261, and the participant in *Owens* had obtained the payments from the plan pursuant to its terms, not by any fraud or wrongdoing. The court held that, under the construction of Section 502(a)(3) it believed was "mandated by *Mertens*," a claim for reimbursement is not authorized in those circumstances. *Id.* at 1262. The court instead viewed the suit as a "breach of contract claim" in which the remedy sought was "money damages for [the participant's] alleged breach," and it held that such relief is not available under Section 502(a)(3). *Id.* at 1261-1262.

For similar reasons, the Ninth Circuit in *Owens* rejected the contention that a constructive trust could be imposed. The court recognized that the Ninth Circuit had previously held that a constructive trust constitutes an equitable remedy under ERISA. But it held that remedy was unavailable in *Owens* because "a constructive trust is born from some form of ill-gotten gain of another's property," and the participant in *Owens* had not obtained the payment of medical expenses from the plan "by any form of fraud, duress, or unconscionable behavior," or as a result of any breach of fiduciary duty. 122 F.3d at 1261.[8]

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[8] The Ninth Circuit reaffirmed the substantive holding of *Owens* in *Cement Masons* (see note 7, *supra*), holding that, like *Owens*, the case involved a claim for contractual reimbursement, and not restitution, because the participant did not receive the payments from the plan through fraud or wrongdoing. 197 F.3d at 1006-1007. The court rejected the argument that *Cement Masons* was distinguishable from *Owens* because the plan in *Cement Masons* established an automatic lien on any third-party recovery. The court held that the plan's request for declaratory and injunctive relief regarding the propriety of enforcing the lien was

SUMMARY OF ARGUMENT

A. A civil action constitutes an action for "appropriate equitable relief" within the meaning of Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(3), when it seeks to redress a violation of, or to enforce, a term of an ERISA plan that requires a participant or beneficiary to reimburse the plan out of a recovery from a third-party tortfeasor. The court of appeals erred in characterizing such an action as one seeking money damages for a breach of contract, which constitute legal relief not available under Section 502(a)(3). That characterization disregards both the strong support in traditional equitable principles for requiring such relief, and this Court's holding that the common law of trusts provides a "starting point for analysis [of ERISA] . . . [unless] it is inconsistent with the language of the statute, its structure, or its purposes." *Harris Trust & Sav. Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238, 250 (2000) (quoting *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 447 (1999)).

Consistent with those principles, an action to enforce a reimbursement term of a plan is properly viewed as an action for equitable relief because it seeks to prevent unjust enrichment of the participant or beneficiary and because the relief is measured by the unjust gain to the defendant, not by the loss to the plan. Such a reimbursement action is analo-

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nothing more than a request for "a mechanism to enforce, or to obtain the equivalent of, a damage remedy." *Id.* at 1007.

In *Ellis*, the Ninth Circuit again reaffirmed *Owens*, rejecting the Eleventh Circuit's view that *Owens* was "based on an 'unduly narrow reading of *Mertens*.'" 202 F.3d at 1248 (quoting *Blue Cross & Blue Shield* v. *Sanders*, 138 F.3d 1347, 1353 n.5 (11th Cir. 1998)). The Ninth Circuit reasoned that *Owens* does not conflict with *Mertens* because *Owens* does not bar all claims for monetary relief under Section 502(a)(3) and recognizes that restitution and constructive trusts may be appropriate, "provided some fraud or wrong-doing is shown." *Id.* at 1249.

gous to a traditional suit in equity to enforce an agreement by a beneficiary to pay money into a trust, or to obtain repayment from a beneficiary of an advance made from a trust.

B. In *Mertens* v. *Hewitt Associates*, 508 U.S. 248 (1993), the Court held that "appropriate equitable relief" under Section 502(a)(3) means "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* at 256. Equity typically provided a variety of remedies to prevent unjust enrichment, including restitution, constructive trust, equitable lien, subrogation, and specific performance. A court sitting in equity has the flexibility to choose which of those types of relief is most appropriate in the circumstances of the particular case.

C. The Ninth Circuit is wrong in believing that *Mertens* limits the availability of restitution and constructive trusts in actions under Section 502(a)(3) to cases involving fraud or other wrongdoing. Under the court of appeals' view, the reimbursement terms of an ERISA plan cannot be enforced under Section 502(a)(3) because the participant or beneficiary was authorized to receive payment from the plan as an initial matter. But the *Mertens* Court referred to the availability of "restitution of ill-gotten plan assets or profits" merely as an example of "appropriate equitable relief" under Section 502(a)(5); the Court did not purport to limit restitution to those circumstances. 508 U.S. at 260. Indeed, elsewhere in *Mertens* the Court explained, without further limitation, that "equitable relief" under Section 502(a)(3) means "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* at 256 (emphasis omitted). Under well-established principles of equity, wrongdoing is not an essential element of a claim for

restitution or a constructive trust, as the Court recently confirmed in *Harris Trust*, 530 U.S. at 251.

ARGUMENT

AN ACTION MAY BE BROUGHT UNDER SECTION 502(a)(3) OF ERISA TO ENFORCE OR REDRESS A VIOLATION OF AN ERISA PLAN TERM THAT REQUIRES A PARTICIPANT OR BENEFICIARY TO REIMBURSE THE PLAN FOR MEDICAL EXPENSES RECOVERED FROM A THIRD PARTY

Section 502(a)(3) of ERISA provides, *inter alia*, that a fiduciary of a plan governed by ERISA may bring a civil action "to enjoin any act or practice which violates * * * the terms of the plan," and "to obtain other appropriate equitable relief * * * to redress such violations or * * * to enforce * * * the terms of the plan." 29 U.S.C. 1132(a)(3).[9] In *Mertens* v. *Hewitt Associates*, 508 U.S. 248 (1993), the Court held that, for purposes of Section 502(a)(3), "equitable relief" does not mean whatever relief could have been provided in a case by a court in equity, because that category would include remedies that are traditionally legal, but that an equity court could grant in certain circumstances. *Id.* at 256-257. Rather, the Court held that the term "equitable relief," as used in Section 502(a)(3), means "those categories of relief that were *typically* available in equity (such as

[9] Section 502(a)(3) authorizes suits by "a participant, beneficiary, or fiduciary." 29 U.S.C. 1132(a)(3). Petitioners alleged in their first amended complaint that petitioner Earth Systems is the plan administrator and, as such, is authorized to bring the action under Section 502(a)(3). J.A. 89. We agree that Earth Systems, as the plan administrator, is a fiduciary of the plan, see 29 U.S.C. 1002(21)(A), and, thus, authorized to bring an action under Section 502(a)(3). The Court need not determine the status of the other petitioners or their authority to sue under Section 502(a)(3). See *Health Cost Controls of Ill., Inc.* v. *Washington*, 187 F.3d 703 (7th Cir. 1999) (Posner, C.J.) (holding that the assignee of a plan may sue under section 502(a)(3)), cert. denied, 528 U.S. 1136 (2000).

injunction, mandamus, and restitution, but not compensatory damages)." *Id.* at 256. The Court stated, for example, that, under Section 502(a)(3), a defendant "may be enjoined from participating in a fiduciary's breaches, compelled to make restitution, and subjected to other equitable decrees." *Id.* at 262.

In their first amended complaint, petitioners sought relief that is typically available in equity, including an injunction to enforce the terms of the plan that expressly provide for reimbursement, to prevent respondents from violating those terms, to require respondents to reimburse the plan in "the amount of $411,157.11 out of any proceeds they recovered from third parties," and to prevent respondents from disposing of any funds received pursuant to settlement of their claims against third parties. J.A. 92, 94-95. They also sought "any other relief" to which they are entitled. J.A. 95. Petitioners' suit thus comes within the plain meaning of Section 502(a)(3) as a suit to enjoin an act that violates the terms of a plan, and to obtain other "appropriate equitable relief" to redress such a violation and to enforce the terms of a plan.

The Ninth Circuit's contrary conclusion was based on its view that reimbursement of funds to a plan out of payments made to a participant or beneficiary by a third party is not equitable relief. Pet. App. A3-A4. That conclusion rests on two faulty premises. First, the Ninth Circuit believed that an action to enforce a reimbursement term of a plan is a suit seeking "money damages" for a breach of contract, a form of legal relief that is not available under Section 502(a)(3). *Owens*, 122 F.3d at 1261-1262; *Cement Masons*, 197 F.3d at 1006-1007. Second, the Ninth Circuit believed that equitable relief in the form of restitution or a constructive trust is not available in actions to enforce a reimbursement term of a plan because the plan participant or beneficiary from whom reimbursement is sought did not obtain the plan funds in the

first instance through fraud or other wrongdoing. *Ibid.* Both of those premises are contrary to this Court's precedents and must be rejected to ensure proper enforcement of ERISA plans.

A. A Suit To Enforce A Reimbursement Term Of An ERISA Plan Constitutes An Action For Appropriate Equitable Relief, Not Money Damages, Because It Seeks To Prevent Unjust Enrichment

1. An action to enforce a term of an ERISA plan that requires a participant or beneficiary to reimburse the plan for expenses recovered from a third party is an action to prevent the participant or beneficiary from being unjustly enriched. When a plan expressly conditions the payment of medical benefits on subsequent reimbursement to the plan out of funds recovered by the participant or beneficiary from a third-party tortfeasor, the participant or beneficiary is unjustly enriched when he or she retains the amount recovered from a third party and does not reimburse the plan. An action to enforce such a reimbursement term is properly brought as an equitable action to prevent unjust enrichment through that double recovery. Restatement of Restitution § 1, at 12-15 (1937).

The relief sought in an action to remedy unjust enrichment is measured by the unjust gain to the defendant, not by the harm to the plaintiff. Consistent with that theory of recovery, petitioners sought reimbursement from respondents in "the amount of $411,157.11 *out of any proceeds they recovered from third parties.*" J.A. 92 (emphasis added).[10]

[10] The district court concluded that the plan and the right-of-recovery agreement differed regarding the scope of reimbursement required. See note 6, *supra*. The court of appeals did not address that ruling and related questions regarding the proper interpretation of the plan, the meaning and validity of the right-of-recovery agreement, and the effect of the state-court judgment. Those issues may properly be considered by the court of appeals on remand.

Moreover, unlike an award of money damages, which "substitutes money for the original condition or thing to which the plaintiff was entitled," the reimbursement sought here would give petitioners the very thing to which they are entitled under the terms of the plan. 1 D. Dobbs, *Law of Remedies* § 3.1, at 279-280 (2d ed. 1993). A judicial order requiring respondents to reimburse the plan in accordance with the plan terms is the sort of relief that is typically available in equity because it would compel specific performance of an obligation to pay money. Indeed, it would compel reimbursement of payments that were previously made by the plan on the *express condition* that reimbursement would be required if the participant or beneficiary recovered from a third party.

If a beneficiary's recovery from a third-party is less than the total expenses paid by the plan, the plan may not obtain reimbursement in excess of the third-party recovery. And the plan may not recover damages to compensate the plan for the loss of the use of the funds between the time it paid the medical benefits on behalf of the beneficiary and the latter's recovery from the third party. Petitioners' action thus seeks merely to restore the status quo and to prevent unjust enrichment to the extent of respondents' recovery from the third party. Cf. *Tull* v. *United States*, 481 U.S. 412, 422 (1987). If equitable reimbursement is ordered in these circumstances, respondents will not lose anything to which they are entitled under the terms of the plan, and the plan will not gain anything to which it is not entitled under the terms of the plan.

2. Petitioners' suit is not an action for contract damages, as the court of appeals would have it. See Pet. App. A3-A4; *Owens*, 122 F.3d at 1262. That characterization of the suit disregards the background of trust law against which ERISA plans are established and instead treats the parties'

relationship as a garden-variety, arms'-length contract.[11] An ERISA plan, like an ordinary trust, is not merely one type of contract. G. Bogert & G. Bogert, *The Law of Trusts and Trustees* § 17, at 215-216 (rev. 2d ed. 1984); cf. *Chauffeurs Local No. 391* v. *Terry*, 494 U.S. 558, 568 (1990) ("The nature of an action is in large part controlled by the nature of the underlying relationship between the parties."). In particular, the assumption of fiduciary duties under an ERISA plan is analogous to the assumption of such duties under an ordinary trust, which is based not on contract, "but rather on the effect of a conveyance" that confers upon beneficiaries an equitable interest in the trust res. G. Bogert & G. Bogert, *supra*, § 17, at 215-216.[12]

Some ERISA plans do not provide for a formal trust account. For example, employee welfare benefit plans, such as the plan in this case, are exempt from ERISA's minimum

[11] Of course, for the reasons already discussed, even in the case of an ordinary contract, an equitable action will lie to prevent unjust enrichment and to compel specific performance of an obligation to pay money.

[12] Although employers typically contribute the bulk of the funds for ERISA health plans, the employees who participate in and are beneficiaries of the plan often contribute substantial amounts as well. Employees of small firms pay on average 33% of health plan premiums, while employees in large firms pay 22%. See Pet. at 6-7, *Reynolds Metals Co.* v. *Ellis*, *supra* (No. 99-1787) (citing *Private Health Insurance—Impact of Premium Increases on Number of Covered Individuals Is Uncertain: Hearings Before the Subcomm. on Employer-Employee Relations of the House Comm. on Education and the Workforce*, 106th Cong., 1st Sess. (1999) (statement of William J. Scanlon, Director, Health Financing and Public Health Issues, General Accounting Office)). In addition, employer-funded plans can arise by virtue of collective bargaining agreements, in which, presumably, employee-beneficiaries expressly trade off other benefits, such as higher wages, for medical insurance. The beneficiaries contribute in that way as well, albeit indirectly. See Central States Mot. for Leave to File Amicus Curiae Br. in Support of Pet. 1. Indeed, benefits under an ERISA health plan may generally be considered an example of compensation in lieu of salary because they are part of an employee's overall compensation package.

funding standards, see 29 U.S.C. 1081(a)(1), and do not generally establish trust accounts, although if the plan receives contributions from participants or beneficiaries, it must segregate such plan assets from the employer's general assets, 29 C.F.R. 2510.3-102. The Court has made clear, however, that the type of plan involved in a particular case does not alter the analysis under ERISA where the statutory text does not distinguish between different types of plans. See *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 105, 111 (1989) (Court guided by principles of trust law in case involving employee welfare benefit plan for which separate trust fund had not been established); *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 443-444 (1999) (plan sponsors who alter the terms of a plan are not fiduciaries, and "are analogous to the settlors of a trust," regardless of whether the plan is a pension benefit plan, a welfare benefit plan, a contributory plan, a noncontributory plan, or "any other type of plan") (citation omitted).

This Court has repeatedly held that the common law of trusts provides a "starting point for analysis [of ERISA] . . . [unless] it is inconsistent with the language of the statute, its structure, or its purposes." *Harris Trust & Sav. Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238, 250 (2000) (quoting *Hughes Aircraft Co.*, 525 U.S. at 447); see also *Firestone Tire & Rubber Co.*, 489 U.S. at 110-111. Reference to the common law of trusts in this case demonstrates the appropriateness of several equitable remedies in a case such as this.

As beneficiaries of an ERISA plan, respondents owe various duties to the plan, and they would owe duties to other beneficiaries under established common-law trust principles. "Co-beneficiaries are owners of equitable interests in the same res * * * . They are in a fiduciary relation to each other in the sense that one beneficiary may not secretly secure for himself a special advantage in the

trust administration." G. Bogert & G. Bogert, *supra*, § 191, at 478 (1979); see also Restatement (Second) of Trusts §§ 251-255, at 633-642 (1959) (describing duties and liabilities of beneficiary to trust); 3A A. Scott & W. Fratcher, *The Law of Trusts* §§ 250-254, at 358-378 (4th ed. 1988) (same).

Moreover, suits could typically be brought in equity to enforce an agreement by a beneficiary to pay money into a trust. 3A A. Scott & W. Fratcher, *supra*, § 252, at 366; Restatement (Second) of Trusts, *supra*, § 252, at 635-636. An action likewise could be brought in equity against a beneficiary for instigating a breach of trust and to restore payments improperly made to the beneficiary from the trust. G. Bogert & G. Bogert, *supra*, § 191, at 478-485; 3A A. Scott & W. Fratcher, *supra*, §§ 253-254.2, at 368- 378; Restatement (Second) of Trusts, *supra*, §§ 253-254, at 636-640. And an equitable action was available against a beneficiary for repayment of an advance made by the trust. *Id.* § 255, at 640-642. See generally 3A A. Scott & W. Fratcher, *supra*, §§ 251, 252, at 363, 366 (A beneficiary may be liable to the trust estate based on the broad equitable principle that "a person entitled to participate in a fund and also bound to contribute to the same fund cannot receive the benefit without discharging the obligation.").

An action to enforce the reimbursement terms of an ERISA plan in order to prevent unjust enrichment of a participant or beneficiary fits comfortably within the scope of those traditional claims in equity. Such an action is analogous to both an action to enforce an agreement by the beneficiary to pay money into the trust, and an action for repayment of an advance made from the trust. Like those actions, reimbursement pursuant to the terms of an ERISA plan furthers the underlying trust objectives and enhances the functioning of the plan by providing specified benefits to all employees and their dependents, while also containing costs and preserving the plan assets to satisfy further

claims. *Mertens*, 508 U.S. at 262-263; *Varity Corp.* v. *Howe*, 516 U.S. 489, 514 (1996).

B. "Equitable Relief" Includes An Order To Prevent Unjust Enrichment Resulting From A Participant's Or Beneficiary's Failure To Abide By A Reimbursement Term Of An ERISA Plan.

1. Petitioners' action for reimbursement seeks equitable relief within the meaning of Section 502(a)(3) notwithstanding that it would, if successful, result in an order for payment of money. This Court has expressly recognized that an award of monetary relief is not necessarily legal relief. In *Chauffeurs Local No. 391*, the Court explained, for example, that monetary relief is equitable where it is "restitutionary, such as in 'action[s] for disgorgement of improper profits,'" 494 U.S. at 570 (quoting *Tull*, 481 U.S. at 424), and where it is "incidental to or intertwined with injunctive relief," *id.* at 571 (quoting *Tull*, 481 U.S. at 424); see also *Harris Trust*, 530 U.S. at 240 (discussed at pp. 29-30, *infra*); *Curtis* v. *Loether*, 415 U.S. 189, 197 (1974); *Porter* v. *Warner Holding Co.*, 328 U.S. 395, 402 (1946). And the Court also has held in other circumstances that a suit for monetary reimbursement may be considered to be one for "specific relief" rather than "money damages." See *Bowen* v. *Massachusetts*, 487 U.S. 879, 893-896, 899-901 (1988).[13]

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[13] In *Bowen* v. *Massachusetts*, the Court held that the provision of the Administrative Procedure Act that precludes actions against federal agencies seeking "money damages" (see 5 U.S.C. 702) does not bar a district court action by a State seeking review of a decision by the Department of Health and Human Services denying reimbursement for certain expenditures under the State's Medicaid program. The Court held that the State's request for monetary relief was in the nature of an equitable action for specific relief to obtain money to which the State allegedly was entitled under the federal Medicaid statute. See also *Department of the Army* v. *Blue Fox, Inc.*, 525 U.S. 255, 262 (1999) ("*Bowen*'s interpretation of § 702 thus hinged on the distinction between specific relief and substitute relief, not between equitable and nonequi-

As we explain below, restitution and specific relief are but two of a number of remedies typically available in equity that may be appropriate in an action under Section 502(a)(3) of ERISA to enforce a term of a plan providing for reimbursement to the plan out of a third-party recovery. Whether the appropriate remedy in any particular case is restitution, specific relief, or another form of equitable relief may depend on the circumstances of that case. Flexibility in determining the nature of the relief that is appropriate in a given case is characteristic of suits in equity. Accordingly, courts entering an equitable judgment "may vary, qualify, restrain, and model the remedy so as to suit it to mutual and adverse claims, controlling equities, and the real and substantial rights of all the parties." 1 J. Story, *Equity Jurisprudence* § 28, at 24 (14th ed. 1918); see, *e.g.*, *Albemarle Paper Co.* v. *Moody*, 422 U.S. 405, 415-417 (1975).

Moreover, because of the expansive preemption provisions of ERISA, which supersede state laws that relate to covered employee benefit plans (29 U.S.C. 1144(a); see *Egelhoff* v. *Egelhoff*, 121 S. Ct. 1322 (2001)), a cause of action presumably would not lie against a participant or beneficiary under state law to enforce a reimbursement term of a plan. Compare *FMC* v. *Holliday*, 498 U.S. 52 (1980) (ERISA preempts state law precluding self-funded employee welfare benefit plans from exercising rights under plan provisions requiring member to reimburse plan if member recovers from third-party tortfeasor). An action under Section 502(a)(3) therefore is likely to be the only avenue of relief for a plan fiduciary. Thus, adoption of the Ninth Circuit's view—that Section 502(a)(3) is not available to enforce such a reimbursement term—could render such a plan term

table categories of remedies."). Although *Bowen* and *Blue Fox* addressed a distinct question concerning the meaning of "money damages" in 5 U.S.C. 702, those cases are instructive insofar as they recognize that some actions for monetary relief *are* suits for "equitable" relief.

altogether unenforceable, contrary to the purposes of ERISA.

2. Consistent with the principles set forth above, the courts of appeals have recognized various types of equitable relief in actions under ERISA plans that provide for reimbursement to the plan out of a third-party recovery, recognizing that, whatever remedy is used to afford relief, the plan fiduciary is "seeking an equitable remedy against [the participant or beneficiary] to ensure her compliance with the terms of the Plan." *Administrative Comm.* v. *Gauf*, 188 F.3d 767, 770 (7th Cir. 1999) (citing as examples the fiduciary plaintiff's request for "'specific performance and enforcement' of the contract and an 'order enjoining [the participant] from continuing to violate the terms of the plan'").[14] Providing appropriate equitable relief to plan fiduciaries to enforce reimbursement terms of ERISA plans helps to maintain plan assets for the benefit of all beneficiaries, and furthers one of the stated purposes of ERISA—that of "providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). See also *Varity Corp.*, 516 U.S. at 512 (characterizing Section 502(a)(3) as a "safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy").

[14] ERISA plans attach different labels to the right of the plan to recover previously-made payments out of a third-party recovery received by a participant or beneficiary, and sometimes use differing terms interchangeably. See 16 L. Russ, *Couch on Insurance* § 226:1, at 226-11, § 226:4, at 226-15 to 226-17 (3d ed. 2000); see also *id.* § 222:2, at 222-11 to 222-12 ("The right of an insurer to recover payments made pursuant to its policy from a third party which caused the loss, or from the person to whom the payment was made, generates considerable confusion because of overlap between, and misuse of," the terms "subrogation," "recoupment," "restitution," reimbursement," and "recovery."); *id.* § 222.22, at 222-13 to 222-14 (noting distinctions among subrogation, liens, and assignments).

a. An action for reimbursement to prevent unjust enrichment may properly be brought as an equitable action seeking restitution. See Restatement of Restitution, *supra*, § 1, at 12-15 (restitution is an appropriate equitable remedy to prevent unjust enrichment); 1 D. Dobbs, *supra*, § 4.1(1), at 552, 556 (same). "Restitution is limited to 'restoring the status quo and ordering the return of that which rightfully belongs to the purchaser or tenant.'" *Tull*, 481 U.S. at 424 (quoting *Porter*, 328 U.S. at 402). Restitution to prevent unjust enrichment, which is measured by the defendant's gain, not the plaintiff's loss, differs in "goal or principle from damages, which measures the remedy by the plaintiff's loss and seeks to provide compensation for that loss." 1 D. Dobbs, *supra*, § 4.1(1), at 555; Restatement of Restitution, *supra*, § 1, cmt. e at 14.[15]

In *Harris Trust*, this Court held that restitution is available under Section 502(a)(3) to remedy violations of Title I of ERISA. 530 U.S. at 243, 250-251, 253 (restitution available against nonfiduciary party in interest who participated in prohibited transaction). Because Section 502(a)(3) affords the same relief for violations of a plan as it does for violations of the Act itself, restitution should likewise be available here to enforce a reimbursement term of the plan. Here, of course, petitioners seek restitution from a beneficiary who is *retaining* funds in contravention of the terms of the plan, even though there was no violation of the plan when the funds were first advanced to the beneficiary. The Seventh Circuit has specifically held that a suit for restitution in comparable circumstances is an action for "appropriate

[15] Although restitution may be viewed as a legal remedy when awarded in an action at law, it is properly viewed as equitable relief where, as here, it is sought in a traditional action in equity to prevent unjust enrichment. See *Reich* v. *Continental Cas. Co.*, 33 F.3d 754, 755-756 (7th Cir. 1994) (Posner, C.J.), cert. denied, 513 U.S. 1152 (1995). See also *Washington*, 187 F.3d at 710.

equitable relief" under Section 502(a)(3), see *Harris Trust & Sav. Bank* v. *Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (1995), and the Fourth Circuit has expressed a similar view, see *Provident Life & Accident Ins. Co.* v. *Waller*, 906 F.2d 985, 988 n.5, cert. denied, 498 U.S. 982 (1990). Those courts articulated similar standards for establishing an entitlement to restitution and determined that the plan's reimbursement claim before them easily sufficed.[16] As the Fourth Circuit put it, "the facts of the instant case fit the archetypal unjust enrichment scenario. * * * [T]he result in this case is an inequitable one; the record indicates [the beneficiary] received a double recovery despite knowing about the plan's reimbursement provision." *Id.* at 993.

b. A constructive trust is another appropriate equitable remedy in an action under Section 502(a)(3) of ERISA seeking reimbursement out of a third-party recovery. This Court described that remedy in *Harris Trust*: "Whenever the legal title to property is obtained through means or under circumstances 'which render it unconscientious for the holder of the legal title to retain and enjoy the beneficial interest, equity impresses a constructive trust on the property thus acquired in favor of the one who is truly and equitably entitled to the same, although he may never, perhaps, have had any legal estate therein.'" 530 U.S. at 250-251 (quoting *Moore* v. *Crawford*, 130 U.S. 122, 128 (1889), and 4 J. Pomeroy, *Equity Jurisprudence* § 1053, at

[16] Although the Fourth Circuit in *Waller* found a cause of action for restitution under federal common law, and did not rest its decision on Section 502(a)(3) (see 906 F.2d at 988 n.5, 992-994), it, like the Seventh Circuit in *Harris Trust & Savings Bank* v. *Provident Life & Accident Insurance Co.*, looked to the elements of restitution as described by Professor Corbin: (1) the plaintiffs had a reasonable expectation of payment; (2) the defendants should reasonably have expected to pay, and (3) society's reasonable expectations of person and property would be defeated by nonpayment. See 906 F.2d at 993-994, and 57 F.3d at 615 (both citing C. Kaufman, *Corbin on Contracts* § 19A, at 50 (Supp. 1989)).

119-120 (5th ed. 1941)); accord, *e.g.*, Restatement of Restitution, *supra*, § 160, at 640; 1 D. Dobbs, *supra*, § 4.3(1), at 587. ERISA's legislative history specifically identifies a constructive trust as an example of "appropriate equitable relief." S. Rep. No. 383, 93d Cong., 1st Sess. 105 (1973) ("Appropriate equitable relief may be granted in a civil action. For example, injunctions may be granted to prevent a violation of fiduciary duty, and a constructive trust may be imposed on the plan assets, if needed to protect the participants and beneficiaries."). Consistent with that congressional intent, the Seventh Circuit has correctly held that an action by a plan administrator against a beneficiary for reimbursement of medical benefits as called for by the plan may properly be treated as an action to impose a constructive trust on funds the beneficiary received from a third party, and thus constitutes an action for appropriate equitable relief under Section 502(a)(3). *Health Cost Controls of Ill., Inc.* v. *Washington*, 187 F.3d 703, 710-711 (1999) (Posner, C.J.), cert. denied, 528 U.S. 1136 (2000).

c. Claims such as petitioners' may also properly be characterized as actions "seeking to impose an equitable lien on the [funds received from a third party] or seeking a mandatory injunction directing [the participant or beneficiary] to sign over her claim to the money." *Washington*, 187 F.3d at 711. An equitable lien is another equitable remedy intended to prevent unjust enrichment and may arise out of an express agreement or may be judicially implied. 1 D. Dobbs, *supra*, § 4.3(3), at 601; G. Bogert & G. Bogert, *supra*, § 32, at 395-401; see also *Department of the Army* v. *Blue Fox, Inc.*, 525 U.S. 255, 264-265 (1999) (recognizing propriety of imposing an equitable lien to obtain a security interest in property that the plaintiff may then use to satisfy a claim for unjust enrichment). An equitable lien is imposed and operates like a constructive trust, the difference being that the equitable lien provides a security interest in, rather than

complete title to, the property to which it attaches. 1 D. Dobbs, *supra*, § 4.3(3), at 601; G. Bogert & G. Bogert, *supra*, § 32, at 395-401; Restatement of Restitution, *supra*, § 161, at 650. In this case, no implication of an equitable lien is necessary, because the SPD (see note 2, *supra*) expressly provided that the plan would "have a first lien upon any recovery, whether by settlement, judgment or otherwise," that a beneficiary received from a third party. J.A. 58.[17]

d. Finally, another obvious equitable remedy that may be appropriate in an action to enforce a reimbursement term of an ERISA plan is specific performance, ordered through a mandatory injunction. A suit for an injunction to compel performance of a plan term is plainly authorized by Section 502(a)(3), because it is "[a] civil action * * * brought * * * to enjoin any act or practice which violates * * * the terms

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[17] In addition, in this case, respondent Eric Knudson agreed in the right-of-recovery agreement "that the plan may be subrogated to me or my dependent's rights for any benefits from the other party." J.A. 77. Subrogation is an equitable remedy, Restatement of Restitution, *supra*, § 162, at 653; 1 D. Dobbs, *supra*, § 4.3(4), at 605-606; G. Bogert & G. Bogert, *supra*, § 33, at 401, and is "an established branch of equity jurisprudence," 16 L. Russ, *supra*, § 222:24, at 222-52. At its core, subrogation is intended to prevent unjust enrichment. The question of when an insurer is entitled to subrogation or how much it should receive are questions of equity, even when the subrogation is expressly delineated in an insurance policy. *Id.* § 222:39, at 222-75; see also *id.* §§ 222:8, 222:9, at 222-30 to 222-34; *id.* § 222:20, at 222-47; § 222:28, at 222-61 to 222-63; see generally Restatement of Restitution, *supra*, § 162, at 653.

Although subrogation and reimbursement differ procedurally—in the former, the insurer stands in the insured's shoes against the third-party tortfeasor, while in the latter, it proceeds against the insured and only if the insured obtains a third-party recovery (see L. Russ, *supra*, § 226:1, at 226-10 to 226-12)—both have similar justifications (to prevent unjust enrichment) and substantive effects (preventing double recovery). Cf. *Stillmunkes* v. *Hy-Vee Employee Benefit Plan & Trust*, 127 F.3d 767, 770 (8th Cir. 1997) (state subrogation law covers claim under plan reimbursement clause, but is preempted by ERISA); *FMC Corp.* v. *Holliday*, *supra* (ERISA preempts application of state anti-subrogation and reimbursement statute to reimbursement provision of self-funded ERISA plan).

of the plan, or * * * to obtain other appropriate equitable relief * * * to enforce * * * the terms of the plan." 29 U.S.C. 1132(a)(3).

Unlike the other equitable remedies discussed above, specific performance arises from the parties' contractual relationship. See 4 J. Pomeroy, *supra*, § 1401, at 1033; Restatement (Second) of Contracts, at 162 (1981) ("Topic 3. Enforcement by Specific Performance and Injunction, Introductory Note"); *id.* § 357, cmts. a, c at 163, 165. The remedy is "drawn as best to effectuate the purposes for which the contract was made and on such terms as justice requires." *Id.* § 358(1), at 166; see also *id.* § 358, cmt. a, c at 166, 167-168 (court, acting in equity "to do complete justice," has considerable discretion and flexibility in molding relief); *id.* § 364, at 184 (describing types of unfairness precluding specific performance).

If adequate money damages were available here in an action at law, specific performance relief might be foreclosed. *Raton Water Works Co.* v. *Raton*, 174 U.S. 360 (1899); Restatement (Second) of Contracts, *supra*, § 360, cmt. a at 171 (specific performance not ordered where damages are adequate to protect party's "expectation interest"). *Mertens*, however, precludes the recovery of money damages against non-fiduciaries under Section 503(a)(3). Thus money damages are not available at law, and therefore an injunction ordering specific performance of the reimbursement clause is "appropriate equitable relief" under Section 502(a)(3). See *Blue Cross & Blue Shield* v. *Sanders*, 138 F.3d 1347, 1352 n.5 (11th Cir. 1998); see also 4 J. Pomeroy, *supra*, § 1403, at 1039 (specific performance available where no action at law may be maintained on the contract); Restatement (Second) of Contracts, *supra*, § 359(1) and (3), cmt. c at 169, 170 (specific performance will not be refused even if other remedies, such as restitution, are available).

C. The Absence of Wrongdoing By Respondents In The Initial Receipt Of Benefits Does Not Foreclose Equitable Relief To Require Reimbursement

The Ninth Circuit erroneously interpreted *Mertens* to limit the availability of restitution and the imposition of a constructive trust in actions under Section 502(a)(3) of ERISA to cases involving fraud or other wrongdoing in the initial receipt of payments from the plan. *Ellis*, 202 F.3d at 1248, 1249; *Cement Masons*, 197 F.3d at 1006-1007; *Owens*, 122 F.3d at 1261. Under that view, an action to enforce a plan term providing for reimbursement to the plan of funds recovered from a third party would never support an award of restitution or constructive trust because, by definition, the participant or beneficiary was authorized by the terms of the plan to receive the payment from the plan in the first instance.

A lack of wrongdoing by the participant or beneficiary in receiving the plan's payment of benefits in the first instance does not, however, render restitution or a constructive trust inappropriate in an action to enforce a reimbursement provision. First, the retention of funds received from the third-party tortfeasor by the participant or beneficiary despite his knowledge of the reimbursement obligation constitutes the wrongful *retention* of the funds, whether or not the initial receipt of the payments from the plan was lawful. See G. Bogert & G. Bogert, *supra*, § 471, at 26-29 (1978) ("Wherever equity finds * * * a wrongful holding it will give relief, whether the type of injustice is new or old. The court does not restrict itself by describing all the specific forms of inequitable holding which will move it to grant relief, but rather reserves freedom to apply this remedy to whatever knavery human ingenuity can invent.").

Second, even if the refusal by a participant or beneficiary to comply with an express reimbursement term of a plan were not viewed as wrongful holding of the funds, restitution

and imposition of a constructive trust are still appropriate remedies under this Court's precedents. The Ninth Circuit rested its contrary interpretation of *Mertens* on a statement by the Court identifying "the return of 'ill-gotten' assets or profits taken from a plan" as an example of "appropriate equitable relief" under Section 502(a)(5) of ERISA.[18] See *Owens*, 122 F.3d at 1261 (quoting *Mertens*, 508 U.S. at 260); *Cement Masons*, 197 F.3d at 1006-1007. The *Mertens* Court, however, did not purport to limit restitution to such circumstances. 508 U.S. at 260. Indeed, elsewhere in *Mertens* the Court explained, without further limitation, that "equitable relief" under Section 502(a)(3) means "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but nct compensatory damages)." *Id.* at 256 (emphasis omitted). *Mertens* thus contemplates that equitable remedies, including restitution, may be awarded whenever it would be consistent with principles of equity to do so.

Under established principles of equity, wrongdoing is not an essential element of a restitution claim. 1 D. Dobbs, *supra*, § 4.1(2), at 559; Restatement (Second) of Contracts, *supra*, § 373, at 208-209. Similarly, no showing of wrongdoing or dishonorable conduct by the person having legal title to the asset is required in order to recover through a constructive trust. Indeed, restitution through imposition of a constructive trust is appropriate even where the assets were transferred by mistake, because it is a means of preventing unjust enrichment. 1 D. Dobbs, *supra*, § 4.1(2), at 559-560; *id.* § 4.3(2), at 597-598; see also 5 A. Scott & W. Fratcher, *Scott on Trusts* § 462.2, at 313-314 (4th ed. 1989)

[18] Section 502(a)(5), 29 U.S.C. 1132(a)(5), is the parallel statutory provision that authorizes civil actions by the Secretary of Labor to redress statutory violations. It is worded similarly to Section 502(a)(3), and this Court has interpreted it accordingly. See *Harris Trust*, 530 U.S. at 248-249.

("A constructive trust may arise, however, even though the acquisition of the property was not wrongful. It arises where the retention of the property would result in the unjust enrichment of the person retaining it.").[19] In addition, like a constructive trust, an equitable lien is not limited to cases of wrongdoing or dishonorable conduct. 1 D. Dobbs, *supra*, § 4.3(3), at 602-603.

Finally, in *Harris Trust*, the Court reaffirmed that restitution and imposition of a constructive trust under Section 502(a)(3) are governed by common-law remedial principles, not notions of wrongdoing. The Court there held that the fact that a third party "was not 'the original wrongdoer' does not insulate him from liability for restitution" to a plan of trust property transferred to him in breach of a trustee's fiduciary duty. 530 U.S. at 251.[20] And as the Court also noted, a constructive trust likewise "is based on property, not wrongs." *Ibid.* (quoting 1 D. Dobbs, *supra*, § 4.3(2), at 597); Restatement of Restitution, *supra*, § 160, cmt. d at 643 ("a constructive trust is imposed * * * to take from the defendant property the retention of which * * * would result in * * * unjust enrichment"). A court therefore may enter appropriate equitable relief to compel reimbursement

[19] See also 5 A. Scott & W. Fratcher, *supra*, § 462.2, at 313-314 (4th ed. 1989 & Supp. 2000) (noting that, under ordinary trust law, the historical limitation of a constructive trust as a remedy for breach of trust by fiduciaries has been abandoned); 1 D. Dobbs, *supra*, § 4.3(2), at 597. See also *Washington*, 187 F.3d at 711 (finding no basis "either in ERISA or in the principles of equity" for limiting "the imposition of a constructive trust in an ERISA case" to cases where "there has been a breach of trust"); accord *Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan* v. *Wells*, 213 F.3d 398, 401 (7th Cir.), cert. denied, 121 S. Ct. 441 (2000).

[20] The Court in *Harris Trust* emphasized that "the common law of trusts" limits restitution from "defendants other than the principal 'wrongdoer'" to instances in which the defendant had actual or constructive knowledge of the prohibited nature of the transfer. 530 U.S. at 251. No comparable concern about knowledge arises in a case such as this, because reimbursement is sought pursuant to an express term of the plan.

to the plan of payments made to a participant or beneficiary when reimbursement is required by the terms of the plan.

CONCLUSION

The judgment of the court of appeals should be vacated and the case remanded to that court for further consideration consistent with the analysis set forth above.

Respectfully submitted.

BARBARA D. UNDERWOOD
Acting Solicitor General
EDWIN S. KNEEDLER
Deputy Solicitor General
BETH S. BRINKMANN
Assistant to the Solicitor General

JUDITH E. KRAMER
Acting Solicitor of Labor
ALLEN H. FELDMAN
Associate Solicitor
NATHANIEL L. SPILLER
Deputy Assistant Solicitor
GARY K. STEARMAN
Attorney
Department of Labor

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No. 99-1786

IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE CO.,
Petitioner,

v.

JANETTE KNUDSON
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER AND BRIEF *AMICUS CURIAE* OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) IN SUPPORT OF PETITIONER

GEORGE J. PANTOS
SELF-INSURANCE INSTITUTE
OF AMERICA, INC.
1250 H Street, N.W.
Suite 901
Washington, DC 20005
(202) 463-8161
Counsel for Amicus Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

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To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

The Self-Insurance Institute of America, Inc. (SIIA) respectfully moves this Court, pursuant to Supreme Court Rule 42 (3), for leave to file the accompanying brief in this case as *amicus curiae* in support of the Petitioners and urging reversal of the decision of the Court of Appeals for the Ninth Circuit. In support of this motion, SIIA shows as follows:

1. This motion is necessitated by the refusal of the Respondent to consent to the filing of a brief by SIIA as *amicus curiae*.

2. SIIA is a non-profit corporation of over 700 members, representing almost 15 million Americans, dedicated to the advancement and protection of the self-insurance industry. SIIA's membership

includes users of self-insurance such as employer plan sponsors, as well as service providers such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which exclusively represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans. Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974, ("ERISA") 29 U.S.C. §§ 1001 *et seq.*, concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members. Indeed, SIIA filed a brief as *amicus curiae* and this Court granted SIIA's motion and accepted SIIA's brief as *amicus curiae* in support of the petition for certiorari in this case (Order of January 22, 2001).

3. SIIA has an interest in the ERISA issue presented in this case—whether an employee benefit plan fiduciary may seek to recoup benefit payments advanced to a plan participant where the plan participant receives payments from an individual or insurance carrier due to the negligence of a third party under ERISA Section 502 (a) (3), 29 U.S.C. § 1132 (a) (3)—for three reasons. First, the issue presented is of major concern to the self-insurance industry because the rising cost to employers and plan participants covered under employer sponsored health plans will escalate further if self-insured plans are not able to recoup benefit payments advanced to covered participants in reliance on plan terms which contain a right of recovery. This will result either in reduced health care benefits, or delay in benefit payments pending the outcome of third-party legal action, or higher out-of-pocket costs for covered participants in the form of higher co-payments and deductibles, or both. The Ninth Circuit's decision may even threaten the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees. Second, because many SIIA employer members operate on a multi-state basis, they are legitimately concerned that any erosion of ERISA's provisions will not only severely disrupt the operation of their plans but also will lead to plans abandoning attempts to recover money paid to participants under reimbursement clauses in ERISA plans which have been agreed to in advance by plan participants. Third, if participants retain personal injury settlements contrary to plan terms, the risk of medical expense payments for injuries caused by third-parties will needlessly shift to employer-sponsored plans thus creating a "windfall" for employees who receive recoveries from the responsible party.

WHEREFORE, it is respectfully moved and requested that the Self-Insurance Institute of America, Inc. (SIIA) be granted leave to file the accompanying brief as *amicus curiae*.

Respectfully submitted,

GEORGE J. PANTOS
1250 H Street, N.W.
Suite 901
Washington, DC 20005

Counsel for Self-Insurance Institute of America, Inc.

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IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE CO.,
Petitioner,

v.

JANETTE KNUDSON
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF *AMICUS CURIAE* OF SELF-INSURANCE INSTITUTE OF AMERICA, INC. (SIIA) IN SUPPORT OF PETITIONER

The Self-Insurance Institute of America, Inc. (SIIA) hereby submits this brief in Case No. 99-1786 urging reversal of the decision of the United Sates Court of Appeals for the Ninth Circuit entered in this case on May 10, 2000.

INTEREST OF THE *AMICUS CURIAE*

A statement describing SIIA and its interest in this case is set forth in the preceding motion requesting leave to file this brief *amicus curiae*.

SUMMARY OF ARGUMENT

The Ninth Circuit's implicit rationale that suits by fiduciaries pursuant to plan reimbursement provisions to recoup payments made to a beneficiary cannot be characterized as "equitable relief" under ERISA § 502 (a) (3), 29

U.S.C. § 1132 (a) (3) is unsupportable in light of ERISA's explicit language, the purpose of the Act, and contrary opinions of other Circuits. By failing to recognize that the federal court has subject matter jurisdiction over an action by a fiduciary of an employee benefit plan subject to ERISA to enforce the provisions of a plan, the Ninth Circuit adopts an extreme judicial interpretation which prevents a fiduciary from doing what Congress intended it to do within the scope of ERISA to protect plan assets and the financial integrity of the plan in the interest of plan participants.

The Ninth Circuit's interpretation of ERISA § 502 (a) (3) creates an ill-conceived precedent that directly affects thousands of self-funded health plans which provide benefits to millions of participants. Since the passage of ERISA, SIIA members have established and administered self-funded plans in reliance upon a federal statutory framework and federal common law which expressly recognize the substantial importance of the proper enforcement of ERISA plan terms that allow recoupment of significant amounts of money on behalf of plans and participants. SIIA members are deeply concerned that judicial determinations which prevent recovery of health benefit payments will result in a "windfall" to participants who receive such payments and a "dead loss" to self-funded plans and their participants. This will significantly increase overall health plan costs and will have detrimental implications both for covered participants and beneficiaries who will bear the ultimate cost-shifting burden of those costs, and for the continued growth of self-insured health benefit programs as a viable and cost-efficient alternative to traditional insurance.

ARGUMENT

I. A CIVIL ACTION TO ENFORCE THE TERMS OF AN ERISA PLAN WHICH INCLUDES A RIGHT TO REIMBURSEMENT PROVISION IS AN EQUITABLE ACTION WITHIN THE MEANING OF ERISA SECTION 502 (a) (3)

The express statutory language in Section 502 (a)(3) of ERISA, 29 U.S.C. § 1132 (a) (3), authorizes a plan fiduciary to bring a civil action to enjoin any act that violates the terms of a plan and "to obtain *other appropriate equitable relief* . . . to redress such violations or . . . to enforce . . . the terms of the plan." U.S.C. § 1132 (a) (3). ERISA imposes on fiduciaries a duty to preserve plan assets for the benefit of *all* participants and beneficiaries "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with" Parts I and IV of Title I of the Act. 29 U.S.C. § 1104 (a) (1) (D). ERISA health plans usually include a recovery provision that gives the plan the right to recoup amounts paid to a participant by the plan for medical expenses when payment has been received by the participant from a third party tort feasor.[1] This "right of reimbursement "is designed to prevent unjust enrichment (double recovery) by a single participant in order for the plan sponsor to preserve plan assets to satisfy future claims for *all* participants and beneficiaries—a fundamental principle of ERISA.[2] When a benefit payment is conditioned

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[1] Typically, reimbursement provisions are incorporated in the terms of the plan which are also disclosed to participants in Summary Plan Descriptions (SPDs). It is also a common practice to require participants to sign an agreement promising to reimburse the plan before any medical expenses will be paid. Such reimbursement agreements which are part of the SPD become part of the plan documents enforceable under ERISA.

[2] Additionally, plan fiduciaries who seek to enforce the terms of its provisions can initiate a civil action under the general federal question provisions of 28 U.S.C. § 1331(a). This provides that district courts "shall

on the covered participant's reimbursement to the plan out of funds recovered from a third-party, a participant who retains the amount recovered from a third party and does not reimburse the plan is unjustly enriched.

An action to enforce express plan terms that include a right to recovery provision constitutes an action to obtain "appropriate equitable relief" within the meaning of Section 502 (a) (3). The Court recently confirmed that restitution under Section 502 (a) (3) is governed by common-law remedial principles. *See Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 120 S. Ct. 2180, 2189-2190 (2000). Respondent's reliance on *Mertens v. Hewitt Associates* 508 U.S. 2484 (1993) to limit the meaning of "equitable relief" under 29 U.S.C. § 1132 is overly restrictive. The Ninth Circuit's holding that under *Mertens* an action for restitution under Section 502 (a) (3) is limited to recovery of "ill-gotten gains," *i.e.* "money obtained through fraud or wrong doing" ignores the essential elements of a restitution claim which this Court held in *Harris Trust* is governed by common-law remedial principles, not notions of "wrong doing". The right to *restitution* and the right to *reimbursement* fall within the categories of relief recognized as "equitable" by the Court in *Harris Trust*. Thus, proof that funds were obtained by

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have original jurisdiction of all civil actions arising under the Constitution, laws or treaties, of the United States. "Laws" in this provision has been held by the Supreme Court to include claims founded upon federal common law, *Illinois v. City of Milwaukee*, 406 U.S. 91, 100 (1972). Citing *City of Milwaukee* several courts have held that ERISA actions governed by federal common law "arise under" federal law for purposes of § 1331. *Airco Industrial Gases v. Teamsters H&W Fund*, 850 F.2d 1028 (3rd Cir. 1988); *Whitworth Bros. Storage v. Teamsters Central States Pension Fund*, 794 F.2d 221 (6th Cir.), *cert. den.*, 479 U.S. 1007 (1986); *Northeast Dep't ILGWU v. Teamsters Local 229*, 764 F.2d 147 (3rd Cir. 1985). It appears from these decisions that there should be no significant jurisdictional obstacles to a Plan bringing suit under ERISA to enforce the reimbursement provision set forth in plan documents.

ill-gotten means is not a requirement under common law equitable remedy principles, such as restitution.

In the ERISA context, the right to reimbursement has been recognized by several courts of appeal as an appropriate equitable remedy to prevent participants from collecting from both the plan and the tort feasor (wrong-doer) and failing to reimburse the plan. In *Administrative Committee v. Gauf*, 188 F. 3d 767 (7th Cir. 1999) the Seventh Circuit noted that it "consistently has held that a complaint purporting to state a claim for equitable relief under a reimbursement clause in a benefits contract is an equitable claim for purpose of ERISA Section 502 (a) (3).[3]

The Eleventh Circuit in *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F. 3d 1347 (11th Cir. 1998) concluded that the Ninth Circuit's earlier reliance on *FMC Medical Plan v. Owens*, 122 F. 3d 1258 (9th Cir. 1997) reflects an "unduly narrow reading" of the Court's decision in *Mertens* which stated that "appropriate equitable relief" under 29 U.S.C. § 1132 (a) (3) (B) means *only* relief "*typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Sanders*, 138 F. 3d at 1325. In specifically rejecting this restrictive reading of "appropriate equitable relief," the Eleventh Circuit recognized a suit by a fiduciary to enforce a plan reimbursement term as a suit for specific performance, which it found to be a "traditional form of equitable relief" under ERISA Section 502 (a) (3).[4]

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[3] *See Harris Trust & Savings. Bank v. Provident Life and Accident Ins. Co.*, 57 F. 3d 608, 615 (7th Cir. 1995); *Central States, Southeast & Southwest Areas Health and Welfare Fund v. Neurobehavioral Assocs.* 53 F. 3d 172, 173-174 (7th Cir, 1995).

[4] *See Owens-Illinois v. Lake Shore Land Co., Inc.*, 610 F. 2d 1185, 1189 (3rd Cir. 1979) ("action for specific performance without a claim for damages is purely equitable").

The Eighth Circuit similarly held that federal courts have exclusive jurisdiction over civil actions brought by fiduciaries under Section 1132 (a) (3) for equitable relief to enforce, or redress violations of ERISA plan terms. *Southern Council of Industrial Workers v. Ford*, 83 F. 3d at 969 (8th Cir. 1996).

Moreover, the Ninth Circuit failed to recognize a developing federal common law of unjust enrichment under ERISA. Recent decisions have begun to develop a right of recovery under ERISA federal common law modeled on traditional equitable remedial principles. [5] In *Provident Life & Accident Ins. Co. v. Waller*, the Fourth Circuit held that where the provisions of a Plan provide for repayment of advanced monies, and the result in question is undeniably unjust enrichment, a plan's recovery of payments is consonant with ERISA's purposes.

II. PREVENTING ENFORCEMENT UNDER ERISA OF A RIGHT TO REIMBURSEMENT WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND PARTICIPANTS

A. Health Plan Costs Will Increase

ERISA's preemption language provides a significant impetus for companies to self-fund employee health benefits. Congress helped foster the favorable federal legal regulatory environment that has resulted in a phenomenal growth of self-funded plans and employer sponsored health care.[6] This

[5] *Provident Life & Accident Insurance Co. v. Waller*, 906 F. 2d 985 (4th Cir. 1990) *cert. den.*, 498 U.S. 982 (1990) (recognizes a federal common law of unjust enrichment); *See Luby v. Teamster, Health Welfare and Pension Funds*, 944 F. 2d 1176 (3rd Cir. 1991) (recognizes a right of restitution to the plan for mistaken benefit payments following the rationale of *Waller*.

[6] Approximately 55 million out of 152 million participants in employment based plans (36 percent) were in self-funded plans in 1997. *Employment-Based Health Care Benefits and Self-Funded Plans*, Employee Benefit Research Institute (February 2000). The survey also found that 60 percent of firms with 500 or more employees self-fund their health benefits and 29 percent of firms with 100-499 employees are in self-funded plans. EBRI survey at 5. According to a survey by William M. Mercer, Inc., a total of 68% of employers with indemnity health plans self-insured them in 2000. Greenwald, *Health Cost Volatility May Spur Shift in Self-Funding*, Business Insurance, February 19, 2000 at 3.

growth also reflects recognition of self-insurance as a viable alternative for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.[7]

An important factor which has contributed to this growth within the present federal regulatory framework is the flexibility of plan design. Right to reimbursement clauses, a feature commonly found in employer-sponsored self-funded plans, are designed to preserve plan assets which can be used to pay enhanced benefits to covered participants by allowing recovery of paid medical expenses which are the financial responsibility of other parties.[8] Generally, right to reimbursement provisions permit plan recoveries for medical expenses paid by a plan for injuries sustained in automobile accidents, from product defects, in accidents on private or public property or for malpractice by hospitals and doctors, where

[7] According to a survey by the Kaiser Family Foundation, health care costs increased by 8.3 percent between 1999 and 2000. This was the highest increase reported by the study since 1993. *Health Research & Educational Trust "2000 Annual Employer Benefit Survey"*, Business Insurance, December 18, 2000 at 22. According to a survey by William M. Mercer, Inc. health care costs could rise by an average of 11 percent in 2001. That double-digit increase would come on top of the 8 percent increase in 2000, Business Insurance, December 18, 2000 at 22.

[8] Duplicate Medicare payments are also subject to recovery from beneficiaries by the Health Care Financing Administration for injuries already reimbursed by automobile and liability insurance. *See*, generally, CCH Medicare and Medicaid Guide ¶ 4142 (Vol. 1 at p. 1372); HCFA Reg. §§ 411.20 *et seq.*, CCH Medicare and Medicaid Guide ¶ 20,881.32 to .54 (Vol. 4 pp. 8264-8274.).

such expenses are also payable to participants pursuant to legal action or settlement in civil cases. Such reimbursement does not reduce medical expenses which are otherwise paid to participants in the absence of a third party recovery. They simply eliminate duplicative payments and preserve limited benefit dollars which are used to pay expanded health care benefits to all participants.[9]

Preventing enforcement under ERISA of plan terms which include a right to reimbursement or subrogation, however, results in less money in plans to pay medical benefits thus forcing many employers to reduce or eliminate certain benefits. Faced with higher costs, plan sponsors would be encouraged to defer or delay payment of claims for medical expenses related to third party negligence until the accident liability issues have been fully resolved or until after third party litigation has been terminated. Plan sponsors are likely to amend their plans to exclude coverage for medical expenses related to negligent third-party. In other cases, in order to maintain current benefit coverages and levels, higher plan costs will be shifted to plan participants in the form of higher co-payments and larger deductibles. Inevitably, interference with sound cost-containment health plan practices such as reimbursement clauses will threaten the continued viability of self-insurance as an acceptable method of providing health benefits to participants.

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[9] The subrogation program of *amicus*, Central States, Southeast and Southwest Areas Health and Welfare Fund, for example, has achieved recoveries and savings of approximately $62 million since its inception. Brief of *Amicus Curiae* Central States, Southeast and Southwest Areas Health and Welfare Fund on *Petition for Writ of Certiorari* at 2 in *Cement Masons Health and Welfare Trust Fund for Northern California et.al. v. Stone*, 197 F.3d 1003 (9th Cir. 1999) *petition for cert.* filed 68 U.S.L.W. 3566 (Feb. 22, 2000) (No. 99-140). For 2000, Healthcare Recoveries, Inc., a nationwide provider of healthcare subrogation services, reported subrogation recoveries averaging approximately $4.8 million for each 1 million persons covered by its clients. *SEC 10K Form filed March 27, 2001.*

B. The Administrative Burdens of Operating Self-Funded Plans Will Increase

Another negative effect of disallowing enforcement of plan terms which include a reimbursement provision is the increased complexity which will result from administering self-funded plans on a state-by-state basis. Since adoption of ERISA, such plans have been established and operated on a nationally uniform basis and free from state regulation. If reimbursement clauses in ERISA plans are invalidated, employers may be forced to seek relief in various state courts. Monitoring and compliance with varying and often inconsistent state requirements and precedents will create significant new administrative burdens.[10] Instead of promoting order and greater uniformity, greater fragmentation and confusion will result.

For example, plan amendments which defer payment of accident related claims until after liability issues have been fully and finally resolved would result in disparate treatment of similarly situated plan beneficiaries. Since each state has its own statute of limitations applicable to a participant for bringing a claim, plan beneficiaries covered under a single plan which offers coverage in multiple states would be treated dissimilarly. To the detriment of plan beneficiaries, such plan terms would be certain to cause delay and disparate treatment in the administration of health plans benefits.

C. The Continued Viability of Self-Insurance As An Alternative Method of Providing Health Benefits Is Threatened

It is a long-standing practice that certain risks, including the medical expenses of employees, can be financed by

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[10] For example, in Pennsylvania subrogation or reimbursement is statutorily prohibited in relation to motor vehicle accidents, but in Indiana subrogation or reimbursement is governed by a statute that prorates recoveries in accordance with Indiana law.

employers from their own current revenues. When such benefits are not insured, directly or indirectly, no insurance company is responsible for providing them. Indeed, even prior to ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business." *Farmer v. Monsanto Co.*, 517 S.W.2d 129 (Mo. 1974).

Unlike conventional insurance where the risk of loss is *transferred* to an insurance carrier upon payment of a premium, self-insurance is generally understood to mean the *self assumption* (or retention) of one's own risk of a particular loss. As an integral part of a firm's risk management program, self-insurance can include the assumption of all or part of a firm's risk of loss for health benefits, property and casualty exposures and workers' compensation liabilities. Thus, employers seeking a cost-effective alternative to conventional insurance increasingly have adopted self-insured programs in managing various elements of risk related to the business enterprise.

Considerations which have stimulated the utilization of self-insurance for funding health benefits include direct control over claims settlements, greater flexibility to design and administer health plans to meet specific employee needs, cash flow advantages and freedom from state insurance regulation. For example, firms which pay for health benefits from general assets gain the financial advantage of the time-value of their capital assets. Since medical claims are paid as submitted, firm assets can be retained as working capital and invested. Thus, interest can be earned as funds that otherwise would be paid in the form of premiums for conventional insurance (which includes reserves) are retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA have contributed significantly to the dramatic expansion of self-insured health plans.

CONCLUSION

For the foregoing reasons, we respectfully request that the Court reverse the Ninth Circuit decision in this case.

Respectfully submitted,

GEORGE J. PANTOS
SELF-INSURANCE INSTITUTE
OF AMERICA, INC.
1250 H Street, N.W.
Suite 901
Washington, DC 20005
(202) 463-8161

Counsel for Amicus Curiae

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No. 99-1786

In The

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Writ Of Certiorari To The
United States Court Of Appeals
For The Ninth Circuit

MOTION FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF AND *AMICUS CURIAE* BRIEF OF NATIONAL ASSOCIATION OF SUBROGATION PROFESSIONALS, INC. IN SUPPORT OF PETITIONERS

MARK D. SPENCER*
J. DUDLEY HYDE
ROBERT J. ROSS
**Counsel of Record*
MCAFEE & TAFT
A Professional Corporation
10th Floor, Two Leadership Square
211 North Robinson Avenue
Oklahoma City, OK 73102
(405) 235-9621 telephone
(405) 235-0439 telecopy

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MOTION FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF

The National Association of Subrogation Professionals, Inc. (NASP) moves pursuant to Supreme Court Rule 37.2(b) for leave to file an *amicus curiae* brief in support of Petitioners. This brief is filed with the consent of Petitioners, and a letter from their counsel reflecting their consent has been filed with the Clerk of the Court. After several calls and letters to Respondents' counsel, NASP's counsel has not received a consent letter from Respondents, and is therefore filing this motion to comply with Rule 37.2(b). On June 9, 2000, counsel of record for NASP filed a motion on behalf of the Self-Insurance Institute of America, Inc., for leave to file an *amicus curiae* brief (which was granted by the Court on January 22, 2001), and *amicus curiae* brief, in support of the petition for a writ of certiorari, and Respondents withheld consent to the filing of that brief. NASP is concerned about the abdication by federal court of their exclusive jurisdiction to enforce subrogation and reimbursement provision in ERISA-regulated plans, and the resulting threat to the financial integrity of such plans. For this reason, NASP respectfully requests that its Motion for Leave to File an *Amicus Curiae* Brief be granted.

Respectfully submitted,

MARK D. SPENCER*
J. DUDLEY HYDE
ROBERT J. ROSS
**Counsel of Record*
McAFEE & TAFT
A Professional Corporation
10th Floor, Two Leadership Square
211 North Robinson Avenue
Oklahoma City, OK 73102
(405) 235-9621 telephone
(405) 235-0439 telecopy

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INTEREST OF *AMICUS CURIAE*

The National Association of Subrogation Professionals, Inc. (NASP) submits this brief in support of the position of Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Plan for Employees and Dependants of Earth Systems, Inc.[1]

NASP is a non-profit trade association of insurance company subrogation specialists, attorneys practicing in the field of insurance subrogation and recovery,[2] and vendors serving the subrogation needs of the insurance industry. NASP has approximately 1000 members, representing 150 insurance companies and self-insured entities. The purpose of NASP is "to create a national forum for education, training, networking and sharing of information and, ultimately, the most effective pursuit of subrogation on an industry-wide basis."

Through NASP, members are able to retrieve, organize, exchange information and expand the use of technology to promote subrogation efforts on a cost-effective

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[1] Counsel of record for NASP, Mark D. Spencer, certifies pursuant to Supreme Court Rule 37.6 that this brief was not authored in whole or in part by counsel for a party and that no person or entity, other than the *amicus curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

[2] In this brief and in the case law, the terms "subrogation" (the right to initiate and control litigation against a third party who injured the participant on whose behalf benefits were paid) and "reimbursement" (the right to require a participant to reimburse the plan from any recovery by the participant from the third party) are used interchangeably.

basis. The members of NASP seek to reduce subrogation barriers in support of Congress' enactment of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1468 (ERISA). This includes rendering assistance to courts in their deliberations on significant ERISA subrogation issues of broad concern to members.

NASP has an interest in the ERISA jurisdictional issue presented in this case – whether an employee benefit plan fiduciary may seek to recoup benefits paid in third party liability situations through enforcement of subrogation provisions in the plan under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3).

First, the issue presented has enormous repercussions for every benefit plan in America, including both self-funded and fully-insured plans. Benefit plans and their participants will continue to bear the enormous burden of the escalating costs of offering health benefits if the plans and plan fiduciaries are unable to recover plan funds lost to participants who win judgments against third-party tortfeasors. The financial reality over time is devastating, ultimately resulting in a reduction in health care benefits for all plan participants or a significant increase in costs for the participant.

Second, Federal courts must not impede benefit plans' efforts to utilize the federal statutory mechanisms created to enable plans to enforce the provisions of ERISA and the terms of the plan, including terms requiring subrogation and reimbursement. This result would harm not only the plans, but also all of the participants who rely on the financial integrity of such plans for payment of their medical expenses. Federal courts should protect

benefit plans and their participants and beneficiaries collectively, rather than permit specific participants in sympathetic situations to evade their plan-established reimbursement obligations by forcing plans to wallow through expensive and time-consuming state court lawsuits.

Federal subrogation actions are essential to maintaining the financial health of ERISA plans. The General Accounting Office estimates that of the 144 million individuals with employer-based health coverage in 1989, approximately 117 million were in ERISA health plans. Moreover, it is estimated that 44 million individuals are participants in self-funded ERISA plans.[3] While dated, these figures demonstrate the wide use of ERISA plans, especially self-funded plans. Thus, it becomes even more important for federal courts to enforce ERISA civil actions so that plans can conserve their assets and maintain their financial viability.

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[3] *See* Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (Letter Report, 07/25/95, GAO/HEHS-95-167).

ARGUMENT

If Federal Courts Abandon Their Exclusive Jurisdiction To Enforce Subrogation And Reimbursement Provisions In ERISA-Regulated Plans, This Will Effectively Jeopardize The Financial Soundness Of Such Plans. Federal Courts Cannot Abandon Their Exclusive Jurisdiction Over Subrogation And Recovery Actions By ERISA-Regulated Plans And Those Who Operate Them.

The case at bar involves a plan participant who violated the terms of the plan that required her to disgorge, reimburse and restore funds to the plan from any recovery from a third-party. *Great West Life & Annuity Ins. Co. v. Knudson*, No. 98-56472, 2000 WL 145374 (9th Cir. Feb. 7, 2000). 29 U.S.C. § 1132(a)(3) authorizes the plan's fiduciaries to bring an action for injunctive and equitable relief to enforce the provisions of ERISA and/or the reimbursement terms of the plan, and/or to redress violations thereof. *See Patterson v. Shumate*, 504 U.S. 753, 760 (1992). *Exclusive* federal jurisdiction over this action exists under 29 U.S.C. § 1132(e)(1). Federal courts have adjudicated these types of actions for several years. *See, e.g., Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). The Ninth Circuit held that federal jurisdiction did not exist in this action.

Perhaps the most forceful argument against the Ninth Circuit's ruling comes from the Respondents' own counsel, who told the Court in a letter dated March 20, 2001 that he could not argue in support of that ruling. Thus, the Petitioners, amicus supporting the Petitioners' position, Respondents' counsel, and ostensibly the Solicitor, are all in agreement that the Ninth Circuit's ruling was erroneous. Apparently, only Court-appointed amicus

will undertake the task of attempting to argue to the contrary.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), the Court held that the remedies provided in ERISA's civil enforcement section, 29 U.S.C. § 1132(a), were intended to be exclusive. The Court's analysis of Section 1132(a) in *Pilot Life* was of particular importance:

> The civil enforcement scheme of [Section 1132(a)] is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement section is sandwiched between two other ERISA provisions relevant to the enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan.
>
> * * *
>
> In sum, the detailed provisions of [Section 1132(a)] set forth a comprehensive scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in [Section 1132(a)] of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Pilot Life, 481 U.S. at 52-53, 54 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

The "tools" of Section 1132 include broad equitable and injunctive relief,[4] enforcement by contempt,[5] nationwide service of process,[6] sue-or-be-sued status for benefit plans,[7] *ready* access to the federal courts (including the neutrality, caliber, and resources of Article III judges),[8] etc. This demonstrates that Congress intended to provide an exclusive, comprehensive, and nationwide forum at the federal level for resolving plan-related disputes, and to assure that the interested parties do not become bogged down in state court litigation.[9] This Court has

[4] 29 U.S.C. § 1132(a)(3)(B); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).

[5] 29 U.S.C. § 1132(a)(3)(B)(ii); 29 U.S.C. § 1109; *Pane v. RCA Corp.*, 868 F.2d 631, 636-37 (3rd Cir. 1989).

[6] *See* 29 U.S.C. § 1132(e)(2); *Peay v. Bellsouth Med. Assistance Plan*, 205 F.3d 1206, 1210 (10th Cir. 2000); *Bellaire Gen. Hosp. v. Blue Cross/Blue Shield*, 97 F.3d 822 (5th Cir. 1996); *Cripps v. Life Ins. Co. of N. Am.*, 980 F.2d 1261, 1267 (9th Cir. 1992); *Rodd v. Region Constr. Co.*, 783 F.2d 89, 91 (7th Cir. 1986).

[7] 29 U.S.C. § 1132(d)(1).

[8] 29 U.S.C. §§ 1001(b), 1132(e)(1).

[9] Congress has provided litigants with similar tools in other federal litigation contexts such as the federal interpleader statutes, 28 U.S.C. §§ 1335, 2361. These statutes permit stakeholders to utilize statutory features such as the low jurisdictional threshold of $500.00 or more in dispute; nationwide service of process; orders restraining the initiation or prosecution of related litigation in other state and federal courts, etc. The federal interpleader framework is similar to the federal framework under Sections 1132(a)(3) and (e)(1). *See, e.g., Metropolitan Life Ins. Co. v. Marsh*, 119 F.3d 415, 417-19 (6th Cir. 1997) (noting the equitable nature of interpleader under Section 1132(a)(3)(B)(ii)). The problems that would result if Congress abolished the interpleader statutes (*e.g.*, the inability to obtain jurisdiction and relief in a single nationwide forum) are similar to the problems that result from the Ninth Circuit's restrictive interpretation of Section 1132(a)(3).

held that statutory claims like the one at bar are equitable in nature. *See Mertens*, 508 U.S. at 248.

Unlike certain other civil actions under Section 1132(a), Section 1132(a)(3) does not define a class of proper defendants, and does not articulate the specific relief permitted in each particular situation. In contrast, an action under Section 1132(a)(1)(A) can only be brought against a plan "administrator," defined in 29 U.S.C. § 1002(16)(A), for the relief provided in 29 U.S.C. § 1132(c). Similarly, an action under Section 1132(a)(2) can only be brought against a plan "fiduciary," defined in 29 U.S.C. § 1002(21)(A), for the relief provided in 29 U.S.C. § 1109.[10]

This open-ended nature of Section 1132(a)(3) evidences Congressional intent[11] to permit civil actions for

[10] In 29 U.S.C. § 1132(e)(1), Congress permitted state courts to entertain one and only one type of action within this preempted field – an action for benefits under 29 U.S.C. § 1132(a)(1)(B), which is the only action that can be asserted for benefits, *see Taylor*, 481 U.S. at 62-63. In contrast, the other ERISA civil actions, including Section 1132(a)(3) actions, can only be adjudicated by a federal court.

[11] In *Pilot Life*, this Court discussed the "comprehensive civil enforcement scheme," the "carefully integrated civil enforcement provisions," and the "deliberate care with which ERISA's civil enforcement remedies were drafted" in analyzing Section 1132(a). The inclusion of an open and expansive civil action in Section 1132(a)(3) is significant in this respect.

sweeping relief against a wide variety of potential defendants – including plan participants who fail to honor their plans' reimbursement provisions and those acting in concert with them. In fact, because Congress displaced state causes of action within this completely pre-empted field and replaced them with ERISA's civil causes of action, *see Taylor*, 481 U.S. at 60, 62-66, Section 1132(a)(3) should be considered the "catchall" civil action for participants, beneficiaries and fiduciaries, because it is so open and expansive. A narrow reading of Section 1132(a)(3) (whether in terms of its jurisdictional or remedial scope) only serves to handicap the aforementioned parties from obtaining the access to and relief from the federal courts that is often so desperately needed within this pre-empted field.

An express Congressional goal in ERISA is to protect the "soundness and stability" and "financial soundness" of benefit plans, and to assure their equitable character. 29 U.S.C. § 1001(a). In connection with these objectives, group health plans typically contain subrogation and reimbursement terms. This enables plan fiduciaries to recover money for the plan from a participant who has obtained a judgment or settlement from a third-party tortfeasor. The concept is simple: the participant is injured by the tortuous conduct of a third-party, the participant incurs thousands of dollars in medical expenses for which the plan pays, the participant sues the third-party and settles or recovers a judgment (often encompassing medical expenses), and the participant repays the plan for the sums paid on the participant's behalf. *See Patterson*, 504 U.S. at 760.

The plan terms govern the relationship between the participants and the plans, and articulate an integral condition on which benefits are paid in the first place – plans pay benefits on the condition and expectation that the participant will reimburse the plan if the participant recovers from a third party. Plan fiduciaries utilize the tools under 29 U.S.C. § 1132, specifically including Section 1132(a)(3), to enforce these plan terms, and to protect against any attempts by participants and their attorneys to circumvent them. In essence, the plans seek the well-established equitable remedy requiring the participants to *specifically perform* according to the plan's reimbursement provisions.

One of the primary goals underlying Congress' enactment of ERISA was to protect the plan and all of its participants and beneficiaries collectively, not just one participant. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. at 141-42 & n. 9. Allowing the plan to enforce its reimbursement provisions is fair, otherwise, the participant would receive a double recovery: once from the plan and again from the third-party tortfeasor. Moreover, if participants are not required to reimburse their plans, there are less funds available to pay the meritorious claims of the other participants and beneficiaries. This penalizes the participants and beneficiaries collectively, and threatens the financial soundness of the plans.

The sums of money that are typically at issue are significant, and when left unrecovered results in depletion of plan assets that over time can have a devastating financial impact on the plan and the benefits participants receive. The case at bar is a subrogation action for $411,157.11. *See Knudson*, No. 98-56472, 2000 WL 145374

at *1. It is not unusual, considering the rising cost of health care in the United States and the relative ease of incurring a six-figure hospital bill with even a brief hospital stay, for subrogation actions to be for over a million dollars. *See, e.g., Shannon v. Shannon*, 965 F.2d 542 (7th Cir.), *cert. denied*, 506 U.S. 1028 (1992). Thus, by attempting to avoid the subrogation provisions in the plan – especially when the stakes are high – injured participants threaten the financial integrity of the plan in contravention of 29 U.S.C. § 1001(a). When federal courts help the participants by dismissing Section 1132(a)(3) subrogation actions, this contravenes 29 U.S.C. §§ 1002(b) & 1132(e)(1).

It is important to note that plans typically seek to enforce subrogation provisions only in cases *where the participant received compensation for the injury*. Frequently, however, federal courts refuse to grant this relief or even hear cases in which this relief is sought, by rationalizing away their jurisdictional obligations; for example by asserting that the remedy sought is "money" so the action is not equitable in nature. *See, e.g., Knudson*, No. 98-56472, 2000 WL 145374 at *2; *FMC Med. Plan v. Owens*, 122 F.3d 1258, 1262 (9th Cir. 1997). Of course, the mere fact that a court enters an equitable decree that results in the payment of money does not mean that the action itself is "legal" rather than "equitable." *See, e.g., Chauffeurs, Teamsters & Helpers Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990). For example awards of money "damages" can be equitable when they are restitutionary, as in an action for

disgorgement of improper profits. *Id.* (citing *Tull v. United States*, 481 U.S. 412, 417 (1987)).[12]

In this type of action, the equitable remedy sought is *specific performance* of the terms of the plan that happen to require the payment of money. Additionally, if the participant has already recovered from a third-party tortfeasor, the remedy sought is one of *disgorgement* of funds that are being improperly retained in violation of the terms of the plan under which payment has been made. Federal courts cannot ignore their *exclusive*[13] jurisdiction over ERISA subrogation claims.

In *Thermtron Prods., Inc. v. Hermansdorfer*, 423 U.S. 336, 344 (1976), this Court held that federal district courts cannot remand cases simply because they are "too busy" or do not want to adjudicate them. Congress, not the courts, decides the categories of federal subject matter jurisdiction, and courts are obliged to carry out Congress' will. *See New Orleans Pub. Serv., Inc. v. Council of New Orleans*, 491 U.S. 350, 359 (1989). Moreover, "federal

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[12] The Ninth Circuit's opinion in *Owens*, 122 F.3d at 1262, stands as a perfect example of the "legal" versus "equitable" semantics game that is being played in some of the lower federal courts. Terminology aside, it is clear that the plan and the employer in that case wanted the court to order the participant to restore funds to the plan as required by the terms of the plan. This could be characterized as specific performance, disgorgement, restitution, reimbursement, constructive trust, etc. In accusing the employer and the plan of doing so, it was actually the Ninth Circuit that attempted to "dance around the word," and in doing so, frustrated the plain jurisdictional requirements of ERISA.

[13] 29 U.S.C. § 1132(e)(1).

courts lack the authority to abstain from the exercise of jurisdiction that has been conferred [by Congress]." *Id.* at 358. Thus, federal courts "have no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given. The one or the other would be treason to the Constitution." *New Orleans Pub. Serv.*, 491 U.S. at 358 (quoting *Cohens v. Virginia*, 19 U.S (6 Wheat) 264, 404 (1821)).

The Ninth Circuit's ruling here stands as a prime example of a federal court departing from its jurisdictional obligations under 29 U.S.C. §§ 1001 & 1132(e)(1). While the Ninth Circuit's decision may appear to lighten the federal caseload and help individual participants in sympathetic circumstances retain large sums, it has a devastating financial impact on benefit plans in general. The result is that plans are forced to seek relief in the state judicial systems, which is exactly what Congress intended to avoid by pre-empting state laws under 29 U.S.C. § 1144(a) & (c)(1), by creating an open-ended equitable cause of action to enforce the plan terms under 29 U.S.C. § 1132(a)(3), and by granting exclusive jurisdiction to the federal courts over such actions under 29 U.S.C. § 1132(e)(1).

In *New York State Conf. of Blue Cross/Blue Shield Plans v. Travelers Ins. Co.*, 514 US 645, 656-57 (1995), this Court held that the legislative purpose behind Section 1144(a) is to protect plans and plan sponsors from the varying laws of each state jurisdiction by implementing a federal

statute applicable to all benefit plans.[14] Subrogation actions are properly adjudicated under 29 U.S.C. § 1132(a)(3), and they should be resolved swiftly with a final equitable decree that is enforceable through the uncomplicated remedy of contempt. *See, e.g., Pane v. RCA Corp.*, 868 F.2d 631, 636-37 (3d Cir. 1989) (discussing how decrees under ERISA are enforced through contempt rather than through inefficient and cumbersome state post-judgment proceedings). The federal court simply orders the participant (and all persons acting in concert with the participant) to disgorge the funds at issue and reimburse the plan as required under its terms. Creative efforts by participants and their attorneys to thwart this – for example by attempting to characterize settlement payments as "non-medical," transferring funds to relatives or attorneys, moving to another jurisdiction, etc. – are easily remedied through federal contempt proceedings before the same court that ordered restitution. *See Pane*, 868 F.2d at 636-37.

On the other hand, when benefit plans are forced to litigate claims for reimbursement in state court, with attendant discovery disputes, jurisdictional, service of process and subpoena problems, jury trials, exorbitant litigation fees and costs, and post judgment hide-and-seek games, it is difficult if not impossible for plans to

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[14] *Travelers* also cited the Congressional discussion relating to the scope and purpose of Section 1144(a): " 'with the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.' " *See Travelers*, 514 U.S. at 657.

successfully recover amounts that are plainly due under the terms of the plan. This frustrates the express goals and jurisdictional requirements of ERISA, and permits an inequitable double-recovery to the plan participant.

CONCLUSION

Subrogation provisions in ERISA plans are extremely important in controlling the cost of delivering benefits to working persons. Congress provided a way for plans to recover and replenish their assets by utilizing a federal statutory cause of action to enforce the relevant plan terms and to redress violations thereof. Congress entrusted the federal judiciary with the responsibility of adjudicating such actions. When federal courts ignore their exclusive jurisdiction over ERISA subrogation actions, it either leaves the plans without a remedy, or requires them to seek enforcement in more expensive, cumbersome, inefficient, and political state court proceedings. While this might be *perceived* on a shallow level as beneficial to an injured party, and to the federal caseload, in reality this is nothing more than an improper abdication of federal jurisdiction that has a much broader negative impact on benefit plans, their sponsors, their

participants and beneficiaries collectively, and to the delivery of health benefits to working women and men.

Respectfully submitted,

MARK. D. SPENCER*
J. DUDLEY HYDE
ROBERT J. ROSS
**Counsel of Record*
McAFEE & TAFT
A Professional Corporation
10th Floor, Two Leadership Square
211 North Robinson Avenue
Oklahoma City, OK 73102
(405) 235-9621 telephone
(405) 235-0439 telecopy

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In the Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,

Respondents.

On Writ of *Certiorari* to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* AND BRIEF OF THE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND AS AN *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

WILLIAM J. NELLIS
Secretary to the Board
of Trustees
Central States, Southeast
and Southwest Areas
Health and Welfare Fund
9377 W. Higgins Road
Rosemont, IL 60018
(847) 518-9800

JOHN A. KUKANKOS
Counsel of Record
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One N. Franklin Street
Suite 900
Chicago, IL 60606
(312) 357-9200

Attorneys for Amicus Curiae

Midwest Law Printing Company/Photex — Chicago — (312) 321-0220

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MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund"), pursuant to Supreme Court Rule 37, respectfully moves this Honorable Supreme Court of the United States of America to grant it leave to file a brief *amicus curiae* in support of the position of Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and Health and Welfare Plan for Employees and Dependents of Earth Systems, Inc. (collectively, "Petitioners" or "Great-West") to reverse the decision of the Ninth Circuit Court of Appeals. The Welfare Fund submits its brief *amicus curiae* together with this motion. In support, the Welfare Fund states:

1. On January 22, 2001, this Court granted the Welfare Fund's motion for leave to file a brief as *amicus curiae* in support of the Petition for a Writ of *Certiorari* in this case. The Welfare Fund now moves the Court for permission to file its brief *amicus curiae* in this case which is now before the Court for oral argument.

2. Petitioners have consented to the filing of the Welfare Fund's brief *amicus curiae*. The Welfare Fund has been unable to obtain the consent of Respondents Janette Knudson and Eric Knudson to the filing of the Welfare Fund's brief *amicus curiae*. Petitioners' letter of consent accompanies this motion for filing with the Clerk of this Court.

3. The Welfare Fund is a Taft-Hartley trust and an employee benefit plan under Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & South-*

west Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985). Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country. Under the terms of collective bargaining agreements negotiated between local unions and employers, employers pay contributions to the Welfare Fund to fund benefits for Beneficiaries.

4. The Welfare Fund provides medical, hospital, dental, disability, vision and life benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and not-for-profit. Like Petitioners, the Welfare Fund has implemented a subrogation program which it actively enforces in all jurisdictions where its Beneficiaries reside.

5. The issue in this case is whether an employee benefit plan regulated by ERISA can sue in federal court to obtain reimbursement of paid medical benefits from the proceeds of its beneficiary's personal injury settlement. The resolution of this issue depends upon whether such an action seeks equitable relief under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3).

6. The Welfare Fund seeks leave to file its brief *amicus curiae* to bring to the attention of the Court the effect which the Ninth Circuit's decision will have on large employee benefit plans, such as the Welfare Fund, which operate in many states. For these employee benefit plans, the decision of the Ninth Circuit, if allowed to stand, will cause the exact harm which Congress sought to prevent in enacting ERISA.

7. In enacting ERISA, Congress recognized the importance of employee benefit plans and the problems of administration which conflicting state and local regulation would cause for such plans. Congress further recognized the need for exclusive federal regulation of such plans to ensure uniformity in enforcement of plan terms. This Honorable Court has, on many occasions, noted these laudable goals of ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974)); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

8. The Ninth Circuit's decision, which is in conflict with decisions in other Circuits, directs plans to state court as the exclusive forum for enforcing the terms of the plan and redressing violations of the terms of the plan related to subrogation and reimbursement.

9. As discussed in the brief *amicus curiae*, the decision of the Ninth Circuit will have far-reaching deleterious effects on the Welfare Fund. Directing fiduciaries to state court to enforce plan terms and to seek redress for violations of plan terms will cause the exact patchwork administration of multistate plans which Congress sought to prevent in enacting ERISA. In addition, because ERISA provides for exclusive jurisdiction over such actions, certain state courts may refuse jurisdiction. Because ERISA preempts state laws, and because many states have a wide range of varying state laws which diminish or eliminate subrogation rights, state courts which do entertain jurisdiction may not provide appropriate relief. Contrary to the mandate of ERISA, plan fiduciaries will be unable to administer the plan and enforce plan terms.

10. Moreover, the decision of the Ninth Circuit at issue in this appeal is simply incorrect. Respondents hold settlement funds sufficient to satisfy Great-West's subrogation and reimbursement rights. They hold such funds for Great-West's use and benefit and plan terms require that Respondents return such funds to the plan. Traditional equitable remedies of specific performance, restitution and a constructive trust are all appropriate remedies to prevent Respondents' unjust enrichment.

11. Finally, subrogation realizes significant cost-savings for ERISA plans. Since its inception in 1984, the Welfare Fund's subrogation program has achieved direct reimbursements and savings of approximately $67.5 million. The decision of the Ninth Circuit, if allowed to stand, will result in the diminishment of subrogation recoveries and savings and, ultimately, in the reduction of benefits for Beneficiaries—a result further detracting from ERISA's goals as described in *Shaw*, 463 U.S. at 99, and *FMC*, 498 U.S. at 60.

For each of the above reasons, the Central States, Southeast and Southwest Areas Health and Welfare Fund requests this Honorable Court to grant it leave to file the Welfare Fund's brief *amicus curiae*.

Respectfully submitted,

JOHN A. KUKANKOS
One of the Attorneys for
Central States, Southeast
and Southwest Areas Health
and Welfare Fund

JOHN A. KUKANKOS
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One North Franklin Street
Suite 900
Chicago, Illinois 60606
(312) 357-9200

WILLIAM J. NELLIS
Secretary to the Board of Trustees
Central States, Southeast
and Southwest Areas Health
and Welfare Fund
9377 West Higgins Road
Rosemont, Illinois 60018
(847) 518-9800

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BRIEF OF *AMICUS CURIAE*

I. THE INTEREST OF THE *AMICUS CURIAE*

Central States, Southeast and Southwest Areas Health and Welfare Fund ("Welfare Fund") is an employee benefit plan under Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). *See Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 561-62 (1985), *reh'g denied*, 473 U.S. 926 (1985).[1] Welfare Fund beneficiaries are teamsters and dependents of teamsters (collectively, "Beneficiaries") from local unions throughout the country. These teamsters and their employers negotiate collective bargaining agreements requiring the employers to pay a certain level of contributions to the Welfare Fund in return for a set benefit package offered by the Welfare Fund for that particular contribution level. Each contributing employer executes a participation agreement with the Welfare Fund agreeing, among other things, to pay the required contributions and to abide by all rules and regulations set by the Welfare Fund Trustees who administer the Welfare Fund. Established under the Taft-Hartley Act, the Welfare Fund has ten trustees—five appointed by contributing employers and five elected by the unions whose members are Beneficiaries. *See* 29 U.S.C. § 186.

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[1] As provided in Sup. Ct. R. 37.6, the Welfare Fund confirms that no counsel for any party authored any part of this brief, and that no person other than *amicus curiae*, its members, or its counsel made any monetary contribution to the preparation or submission of this brief. As provided in Sup. Ct. R. 37.3(a), the Welfare Fund states that Petitioners have consented and Respondents have not consented to the filing of the Welfare Fund's brief as *amicus curiae*.

The Welfare Fund provides medical, hospital, dental, vision, life and disability benefits to more than three hundred thousand Beneficiaries who reside in thirty-six states. The Welfare Fund is self-funded and pays benefits directly from the contributions of participating employers. The Welfare Fund is not-for-profit, and its assets are used exclusively to provide benefits for Beneficiaries and to defray the reasonable costs of administering the benefit plan. *See* 29 U.S.C. § 1104(a)(1)(A).

In accord with ERISA's "prudent man" investment standards, Welfare Fund Trustees have implemented cost-containment measures including the promulgation of subrogation and reimbursement provisions. Since its inception in 1984, the Welfare Fund's subrogation program has achieved recoveries and savings totaling approximately $67.5 million.

Since benefit levels are based on actuarial assumptions which assume a certain level of subrogation and reimbursement recoveries, such recoveries are necessary to provide assets sufficient to fund the benefit levels stated in the various benefit plans offered by the Welfare Fund. Like other large multiemployer plans where contribution rates are set pursuant to collective bargaining and participation agreements, the Welfare Fund cannot unilaterally increase contribution rates. Thus, if subrogation recoveries are reduced, benefits provided to Beneficiaries will be correspondingly reduced.

The impact of the Ninth Circuit's decision on the Welfare Fund and other large multistate plans will be substantial. That decision denies ERISA plans access to federal courts to enforce subrogation and reimbursement rights and to redress violations of those rights. As discussed within, the Ninth Circuit's decision will result in

the nonuniform enforcement of plans, an increase in administrative costs for plans, and reduced subrogation recoveries—all to the detriment of plan beneficiaries.

II. SUMMARY OF THE ARGUMENT

The Welfare Fund seeks to bring to the Court's attention the impact which the Ninth Circuit's decision will have on multistate and multiemployer plans such as the Welfare Fund whose Beneficiaries reside in many states. When enacting ERISA into law, Congress recognized the need for exclusive federal regulation to eliminate conflicting state and local regulation of such plans. To achieve these ends, Congress enacted ERISA's preemption provision and directed plan fiduciaries to federal district courts as the exclusive forum over actions to enforce plan terms and redress violations of plan terms. The decision of the Ninth Circuit, which holds that ERISA provides no relief in this case, completely reverses these Congressional mandates.

Because ERISA provides that federal district courts have exclusive jurisdiction over actions to enforce plan terms regarding subrogation, state courts may not entertain such actions. State courts which do accept jurisdiction may not afford sufficient or uniform relief due to ERISA's preemption provision and the varying state antisubrogation laws. Given all of the above, the Ninth Circuit's action will not only result in the exact piecemeal enforcement of plan terms which ERISA was designed to prevent, but will also greatly limit the ability of plan fiduciaries to enforce plan terms as required by ERISA and the common law of trusts. The end result will be higher administrative costs, lower subrogation recoveries, and the loss of benefits for plan beneficiaries.

Finally, the decision of the Ninth Circuit is simply incorrect. As discussed within, Great-West seeks equitable relief in this case. The fact that Great-West is subrogated to Janette Knudson's rights of recovery means that her rights belong to Great-West. Once Janette Knudson asserts those rights and receives money in return, that money properly belongs to Great-West. Great-West is entitled to specific performance of the terms of its plan which require the payment of those funds to the plan. Moreover, when Janette Knudson refuses to surrender those funds to Great-West, she is unjustly enriched. Great-West is also entitled to the additional equitable remedies of restitution of these funds and the imposition of a constructive trust over these funds.

III. ARGUMENT

A. The Decision of the Court of Appeals for the Ninth Circuit, If Allowed To Stand, Will Create the Exact Administrative Morass which ERISA was Designed to Prevent.

1. In Promulgating ERISA, Congress Recognized the Importance of Employee Benefit Plans and the Need for Exclusive Federal Regulation of Such Plans to Ensure Uniformity in Enforcement of the Terms of the Plan.

In enacting ERISA, Congress recognized that employee benefit plans involve the national public interest and stressed the importance of uniform federal regulation of such plans. 29 U.S.C. § 1001(a). Both ERISA's legislative sponsors and this Court have emphasized the necessity for uniform federal regulation of not only the substantive provisions, but also the enforcement provisions applicable to ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29933 (1974));[2] *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

To enable plan Trustees to structure uniform plan provisions for all participants and to seek redress for violations of those provisions, Congress enacted ERISA's preemption provision which preempts state laws which relate to ERISA plans. *See* 29 U.S.C. §1144.[3] To further

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[2] Congress rejected amendments to ERISA which would have required ERISA plans to comply with multiple and potentially conflicting state laws which would raise the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. *Shaw*, 463 U.S. at 99 n.20. Thus, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, stating that "'the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded.'" *Id.* (quoting H.R. Rep. No. 1785, 94th Cong., 2d Sess., at 47 (1977)).

[3] This Court has also recognized the disruptive effect that state regulation would have on ERISA plans. In *Shaw*, the Court, noting that the obligation of the plans to comply with "the varied and perhaps conflicting" requirements of particular state fair employment laws would make nationwide administration of plans more difficult, found that ERISA preempted New York's Disability Benefits Law. 463 U.S. at 105 n.25. In *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), this Court recognized that requiring an employer to adopt different payment formulae for employees inside and outside the State would subject the employer to precisely the burden that ERISA preemption was intended to eliminate. *Id.* at 10. Similarly, in *Egelhoff v. Egelhoff*, 121 S. Ct. 1322

(continued...)

this same uniformity, Congress enacted Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), ERISA's enforcement provision. Section 502(a)(3) allows plans to sue to obtain equitable relief to enforce plan terms and redress violations of plan terms. To ensure uniform enforcement of plan terms, Congress stated that federal district courts shall have exclusive jurisdiction over such actions. *See* 29 U.S.C. § 1132(e).

ERISA's uniform enforcement mechanism complements ERISA's administrative scheme. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court again confirmed that ERISA was designed to achieve uniformity of decision to assist fiduciaries "'to predict the legality of proposed actions without the necessity of reference to varying state laws.'" *Id.* at 56 (quoting H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650). This Court noted ERISA's expectation that federal courts would develop federal common law:

> The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under

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[3] (...continued)
(2001), this Court held that ERISA preempted a Washington statute providing for automatic revocation, upon divorce, of any designation of spouse as beneficiary of a non-probate asset. *Id.* at 1326-29. The Court found the statute to be in direct conflict with ERISA's requirement that the plans be administered in accordance with the plan document. *Id.* at 1329.

> § 502(a) could be supplemented or supplanted by varying state laws.

Pilot Life, 481 U.S. at 56.

2. The Decision of the Ninth Circuit Fosters the Very Harm Which Congress Sought to Prevent in Enacting ERISA.

The Ninth Circuit's decision will create the exact patchwork scheme of regulation and enforcement which Congress sought to avoid in enacting ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). First, denying ERISA plans the right to enforce subrogation rights in federal court under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), will result in the complete abrogation of such rights in certain states. The Ninth Circuit's decision in this case provides just such an example. The relevant state jurisdiction here, California, has already held that because ERISA makes federal district courts the exclusive forum for actions to enforce plan terms, 29 U.S.C. § 1132(e), California state courts cannot entertain jurisdiction in such matters. *Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr.2d 723 (Cal. Ct. App. 1996). *See also Descant v. Administrators of the Tulane Educ. Fund*, 706 So. 2d 618 (La. Ct. App. 1998).

Other state courts, which do entertain jurisdiction, may find no remedy due to ERISA's preemption of state causes of action. Moreover, those state courts which do entertain jurisdiction and overcome ERISA preemption, are invited to apply a panoply of differing state anti-subrogation laws. These laws, in violation of plan terms, diminish subrogation rights and further prevent the uniform enforcement of plan terms. *See Ingersoll-Rand*, 498 U.S. at 142. For example, the laws of some states

prohibit the enforcement of subrogation rights against uninsured motorist recoveries, recoveries by minors, or recoveries which do not make a plan participant whole. Other states reduce the amount of the plan's recovery by an award of *pro rata* attorney's fees under the common fund doctrine.[4]

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[4] Federal courts are often forced to decide whether to apply state laws that would forbid or limit an ERISA plan's subrogation rights. When confronted with this issue, most federal courts have held that ERISA preempts such laws and that the written language of the plan should be followed. *See, e.g., FMC*, 498 U.S. 52 (1990) (ERISA preempts state automobile insurance anti-subrogation law); *Community Ins. Co. v. Richardson*, 172 F.3d 872 (6th Cir. 1999) (ERISA preempts Ohio statute prohibiting reimbursement of medical claims from municipalities); *Electro-Mechanical Corp. v. Ogan*, 9 F.3d 445 (6th Cir. 1993) (ERISA preempts Tennessee statute prohibiting subrogation of health care costs in malpractice cases); *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992) (ERISA preempts North Carolina subrogation statute limiting a self-funded ERISA plan's recovery from third party settlement funds); *Davis v. Line Constr. Benefit Fund*, 589 F. Supp. 146 (W.D. Mo. 1984) (ERISA preempts state law preventing subrogation of an otherwise unassignable personal claim). Courts have also considered application of the common fund doctrine to ERISA plans. *See, e.g., Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938, 940 (5th Cir. 1998); *United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998); *Bollman Hat Co. v. Root*, 112 F.3d 113, 118 (3rd Cir. 1997), *cert. denied*, 522 U.S. 952 (1997); *Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997); *Ryan v. Federal Express Corp.*, 78 F.3d 123 (3rd Cir. 1996). In *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1997), the court ruled that whether ERISA preempts the common fund doctrine depends on the language

(continued...)

The decision of the Ninth Circuit, if permitted to stand, will create huge administrative burdens for multi-state plans such as the Welfare Fund. These plans will have to tailor their subrogation program to conform with the varying laws from state to state regarding subrogation and reimbursement. The patchwork scheme of federal and state regulation of employee benefit plans which Congress rejected when it passed ERISA will become a reality. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9-11 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-08 (1983).

B. If Not Overturned, the Ninth Circuit's Decision Will Diminish a Valuable and Equitable Cost-Saving Mechanism for Self-Funded Plans.

As this Court has recognized, uniformity and equal enforcement of Plan provisions ultimately inures to the benefit of plan participants:

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

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[4] (...continued)
of the benefit plan. In *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1296 (7th Cir. 1993), *cert. denied*, 510 U.S. 916 (1993), and *Fields v. Farmers Ins. Co., Inc.*, 18 F.3d 831, 835-36 (10th Cir. 1994), courts held that the terms of the plan override contrary state laws related to subrogation in Wisconsin and Oklahoma, respectively. *See also* footnote 7, *infra*, pp. 12, 13.

Fort Halifax, 482 U.S. at 11 (1987) (citing H.R. Rep. No. 533, 93rd Cong., 1st Sess., at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650).

Since the laws and regulations applicable to health care benefits vary widely from state to state, the disruptive effect of state regulation is compounded for employee benefit plans, such as the Welfare Fund, which have employees in more than one state. Benefit plans which operate in many states often choose to self-fund benefit payments rather than purchase insurance to cover such benefits. Because state laws vary dramatically, purchasing insurance for plans which operate in many states is inefficient, inequitable and increasingly expensive.[5] It was for this reason that Congress passed the preemption clause of ERISA, 29 U.S.C. § 1144. *See Fort Halifax*, 482 U.S. at 10; *see also FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

Moreover, many cost-containment measures implemented by employee benefit plans transfer actual costs to beneficiaries or restrict the type, length or choice of

[5] The Ninth Circuit's decision will lead plans to reconsider their policy of advancing payment for medical bills related to injuries sustained in accidents. If benefit plans cannot enforce subrogation rights in certain states, and in order to avoid having one employer subsidize the benefits of another employer's employees, multiemployer plans could add plan provisions to exclude from coverage claims related to accidents in those states where the plan's subrogation provision could not be enforced. Although compensating for lost subrogation recoveries, this added layer of administration would delay payment of a beneficiary's benefits, increase the cost of administering the plan, and lead to the hodge-podge administration of plans which ERISA condemned.

medical care. Unlike such cost-containment measures, subrogation and reimbursement provisions merely prevent the duplication of benefits by the plan where other coverage exists for a particular injury or illness. In other words, the participant does not recover twice for accident-related medical damages. The responsibility for the medical care is shifted to the party causing the injury or to the specific-risk insurer which has specifically assumed the kind of risk leading to the injury. Subrogation not only shifts the costs of medical care to the responsible party, but also constitutes a valuable cost-savings device. Since the inception of the Welfare Fund's subrogation program, the Welfare Fund has achieved recoveries and subrogation savings totaling approximately $67.5 million.

C. The Decision of the Ninth Circuit Limits the Ability of Plan Trustees to Administer the Plan in Accordance with ERISA's Mandate.

ERISA requires that every employee benefit plan be established pursuant to a written instrument and that named fiduciaries control and manage the operation and administration of the Plan. 29 U.S.C. § 1102(a)(1). Congress bestowed upon fiduciaries the power and authority to accomplish these objectives by enacting ERISA's enforcement mechanism, Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). Section 502(e) of ERISA, 29 U.S.C. § 1132(e), makes federal district courts the exclusive jurisdiction for actions by fiduciaries to enforce plan terms and redress violations of plan terms. The relief which Section 502(a)(3) allows is "appropriate equitable relief." 29 U.S.C. § 1132(a)(3).

In finding equitable relief unavailable in the instant action by a plan to enforce plan terms against a plan

beneficiary, the Ninth Circuit left plan fiduciaries without a forum in which to bring such actions. As already noted, the relevant state forum in this case, California, has taken the position that it is without jurisdiction to entertain such an action by a plan to enforce subrogation rights. Moreover, as stated previously, in light of ERISA's preemption of state laws and the panoply of state antisubrogation laws, state courts which do entertain jurisdiction may not afford adequate relief.[6]

Subrogation is not a simple contractual matter between an insured and its insurer where state issues predominate. Subrogation involves a core ERISA issue, *viz.*, the recoupment of plan benefits paid to beneficiaries through the enforcement of plan terms by plan fiduciaries. In hardship cases, trustees of the trust must balance the interests of all beneficiaries against the interests of the beneficiary being asked to reimburse the plan. Moreover, in many instances, the enforcement of subrogation rights by a self-funded employee benefit plan involves the interpretation of a plan's precise subrogation provision. All of these are functions best left to the discretion of plan Trustees.[7]

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[6] The impact of the Ninth Circuit's decision has broad implications for ERISA plans beyond subrogation and reimbursement rights. That decision may, for example, prevent plans from obtaining recoveries of overpayments from providers and beneficiaries or from properly coordinating benefits with other plans and insurers.

[7] Plan fiduciaries must decide whether the written terms of the plan include recoveries from tortfeasors as well as their insurers or recoveries from uninsured motorist coverage. *See Health Cost Controls v. Washington*, 187 F.3d 703, 711-12 (7th (continued...)

Because ERISA considerations permeate the enforcement of Plan terms such as subrogation, Congress legislated that federal district courts have exclusive jurisdiction to enforce Plan terms and redress violations of

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[7] (...continued)
Cir. 1999), *cert. denied*, 120 S. Ct. 979 (2000); *Wendy's Int'l, Inc. v. Karsko*, 94 F.3d 1010, 1013 (6th Cir. 1996); *Sunbeam-Oster Co., Inc. v. Whitehurst*, 102 F.3d 1368, 1378 (5th Cir. 1996). Another question of interpretation arises when the written terms of the plan set the priority of allocations between the subrogee and subrogor. *See Hiney Printing Co. v. Brantner*, 243 F.3d 956, 960 (6th Cir. 2001) (applying federal common law make whole rule where plan language was ambiguous as to whether plan's reimbursement rights applied to a partial recovery); *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 280-81 (1st Cir. 2000) (holding that application of the make whole rule is precluded where an ERISA plan unambiguously requires its members to reimburse plan for all benefits paid); *Copeland Oaks v. Haupt*, 209 F.3d 811, 813-14 (6th Cir. 2000) (applying make whole rule where plan language failed to establish plan's priority right over any partial recovery); *Cagle v. Bruner*, 112 F.3d 1510, 1520-22 (11th Cir. 1997) (applying make whole doctrine where plan language did not specifically reject doctrine), *reh'g denied*, 124 F.3d 223 (11th Cir. 1997); *Sunbeam-Oster Co.*, 102 F.3d at 1373-76 (refusing to apply make whole doctrine where plan language was clear and unequivocal in providing plan with right to reimbursement for full amount of benefits paid); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298-99 (7th Cir. 1993) (holding that ERISA plan administrator was not unreasonable in interpreting plan provision as effectively disclaiming make whole doctrine), *cert. denied*, 510 U.S. 916 (1993). *See also Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989) (arbitrary and capricious standard applied when plan gives fiduciary discretionary authority to construe terms of plan).

those terms. These are core ERISA issues best left, as Congress intended, to the federal courts which can ensure the uniformity of enforcement of plan terms which ERISA intends. Contrary to the Ninth Circuit's position, the equitable relief which Congress set forth in ERISA is sufficient to accomplish these objectives.

D. The Decision of the Ninth Circuit is Incorrect. Various Forms of Appropriate Equitable Relief Are Available to Plans Which Seek to Enforce Subrogation and Reimbursement Rights.

1. The Instant Case in Which Plan Trustees Seek to Enforce Plan Terms Against a Plan Beneficiary is Distinguishable from *Mertens v. Hewitt Associates*.

The Ninth Circuit Court of Appeals erred in holding that equitable relief is unavailable to Great-West in the enforcement of its subrogation and reimbursement rights against its beneficiary. In finding no equitable remedy, the Ninth Circuit relied on its prior decision in *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1262 (9th Cir. 1997), which incorrectly interpreted this Court's decision in *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). In *Mertens*, a class of former employees of an ERISA pension plan sued the plan's actuary for an alleged knowing participation in plan fiduciaries' breach of fiduciary duties. *Id.* at 250-51. The plaintiffs in *Mertens* sought only a legal remedy and money damages and not "appropriate equitable relief" under ERISA. *Id.* at 255-56. This court found that requiring a nonfiduciary to make the plan whole for losses it sustained as a result of the alleged breach of fiduciary duties would not constitute "appropriate equitable relief." *Id.* at 255-59.

Unlike the claim in *Mertens* which sought monetary recovery for injury to property, the claim brought by Great-West is an action against a beneficiary by a fiduciary to enforce the specific term of the trust as required by ERISA.[8] Great-West does not seek mere compensatory damages. Instead, Great-West seeks an order requiring its beneficiary to comply with plan terms.

2. A Fiduciary Suing to Enforce Subrogation and Reimbursement Rights Set Forth in the Plan Seeks Specific Performance of Plan Terms.

Plan fiduciaries disburse plan benefits, and beneficiaries receive plan benefits, subject to the terms of the plan including subrogation and reimbursement. When a beneficiary such as Janette Knudson refuses to reimburse the plan as required by plan terms, plan fiduciaries may sue under Section 502(a)(3) of ERISA, 29

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[8] The specific plan terms at issue here provide that when a third party may be liable or legally responsible for expenses incurred by a covered person for a bodily injury, Great-West will pay covered expenses related to treating that injury. Under these circumstances, Great-West will, at its option, have the right to recover from its covered person any payment for benefits paid for treatment of such loss which the covered person is entitled to receive from a third party. The Plan creates a first lien upon any recovery the covered person receives from the third party, the third party's insurer, or from uninsured motorists insurance. If Great-West's covered person makes any recovery therein set forth and fails to reimburse the plan, then the covered person is personally liable to Great-West to the extent of its lien. (Joint App. at 58-59.)

U.S.C. § 1132(a)(3), to specifically enforce the subrogation and reimbursement rights set forth in the plan document. The fact that such specific enforcement requires the plan beneficiary to turn over to the plan sums of money does not change the character of the relief from specific performance of plan terms to money damages. *See, e.g., Administrative Comm. v. Gauf,* 188 F.3d 767 (7th Cir. 1999); *Blue Cross & Blue Shield of Ala. v. Sanders*, 138 F.3d 1347 (11th Cir. 1998); *Southern Council of Indus. Workers v. Ford*, 83 F.3d 966 (8th Cir. 1996).

This Court has also recognized the distinction between an action for specific relief (even when the specific relief is money) and an action for compensatory damages. In *Bowen v. Massachusetts*, 487 U.S. 879 (1988), the state of Massachusetts brought suit in federal district court to overturn a decision rendered by the Secretary of Health and Human Services which disallowed reimbursement under the Medicaid Act. The Secretary, asserting that Massachusetts' claim was for money damages only, argued that Section 702 of the Administrative Procedure Act ("APA"), 5 U.S.C. § 702, mandated dismissal. That section provides, in part:

> An action in a court of the United States *seeking relief other than money damages* . . . shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party.

5 U.S.C. § 702 (emphasis added).

In addressing the Secretary's argument, this Court first recognized the distinction between a legal action for

money damages and an action for specific relief including money. This Court stated:

> Our cases have long recognized the distinction between an action at law for damages—which are intended to provide a victim with monetary compensation for an injury to his person, property, or reputation—and an equitable action for specific relief—which may include an order providing for . . . "the recovery of specific property *or monies*. . . ." The fact that a judicial remedy may require one party to pay money to another is not a sufficient reason to characterize the relief as "money damages."

Bowen, 487 U.S. at 893 (quoting *Larson v. Domestic & Foreign Commerce Corp.*, 337 U.S. 682, 688 (1949), *reh'g denied*, 338 U.S. 840 (1949)).

The Court concluded that Massachusetts' suit was "not a suit seeking money in *compensation* for the damage sustained by the failure of the Federal Government to pay as mandated," but rather a suit "seeking to enforce the statutory mandate itself, which happens to be one for the payment of money." *Id.* at 900. This Court found that Massachusetts' suit was one for specific relief properly brought in federal district court.[9] *Id.*

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[9] In *Bowen*, this Court quoted extensively and approvingly from the D.C. Circuit's decision in *Maryland Dept. of Human Resources v. Department of Health & Human Services*, 763 F.2d 1441 (D.C. Cir. 1985). In *Maryland*, the Court considered, *inter alia*, whether it had federal question jurisdiction over an action against Maryland alleging misspent federal grant moneys received pursuant to Title XX of the Social

(continued...)

Although this Court's decision in *Bowen* did not turn on the distinction between equitable actions and other actions, *Department of Army v. Blue Fox, Inc.*, 525 U.S. 255 (1999), the Court in *Bowen* did note that the specific equitable remedy of specific performance is, in many instances, in the form of money. The *Bowen* Court states as follows:

> Thus, while in many instances an award of money is an award of damages, [o]ccasionally a money award is also a specie remedy. *Id.* Courts frequently describe equitable actions for monetary relief under a contract in exactly those terms. *See, e.g., First National State Bank v. Commonwealth Federal Savings & Loan Association*, 610 F.2d 164, 171 (3d Cir. 1979) (specific performance of contract to borrow money); *Crouch v. Crouch*, 566 F.2d 486, 488 (5th Cir. 1978) (contrasting lump-sum damages for breach

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[9] (...continued)
Security Act. *Id.* at 1443. The resolution of this question depended upon whether Maryland was seeking relief other than money damages. In finding the relief sought by Maryland specific equitable relief, the D.C. Circuit distinguished such relief from money damages:

> The term "money damages," 5 U.S.C. Sec. 702, we think, normally refers to a sum of money used as compensatory relief. Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies "are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled." D. Dobbs, Handbook on the Law of Remedies 135 (1973).

Maryland, 763 F.2d at 1446.

> of promise to pay monthly support payments with an order decreeing specific performance as to future installments); *Joyce v. Davis*, 539 F.2d 1262, 1265 (10th Cir. 1976) (specific performance of a promise to pay money bonus under a royalty contract).

Bowen, 487 U.S. at 895 (quoting *Maryland*, 763 F.2d at 1446). Specific remedies are contrasted with the substituted remedy of money damages. *See* Dan B. Dobbs, *Handbook on the Law of Remedies* § 3.1, at 135 (1973). The specific equitable remedy of specific performance attempts to give the plaintiff the very thing to which he is entitled. *Id.* Plan trustees who seek to enforce plan terms against a plan beneficiary are seeking the equitable remedy of specific performance even when that remedy results in monetary relief. The payment of money is the specific performance required and is not a substituted remedy.[10]

The instant claims, unlike the claims in *Mertens*, are not for the substitute relief of money damages. Like the claims in *Bowen*, where the Secretary sought to enforce a specific provision of a statute, the instant claims are for specific relief. Moreover, the specific relief requested here is equitable relief, *viz.*, the specific performance of the obligations of plan participants set forth in the plan. As this Court recognizes, the fact that the relief happens

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[10] There is also no adequate remedy at law here. As noted previously in Section III A2 of this brief, pp. 7-8, California state courts would afford no relief here. State courts which do entertain jurisdiction may apply ERISA preemption or a variety of state antisubrogation laws to further limit relief in state court.

to be the payment of money to the plan does not change the character of this specific relief to money damages. *See Bowen*, 487 U.S. at 893; *School Comm. of Burlington v. Department of Educ. of Massachusetts*, 471 U.S. at 370-71.

3. Restitution and a Constructive Trust are Additional Equitable Remedies Available to Plans Seeking to Enforce Subrogation and Reimbursement Rights.

Subrogation is "the substitution of another person in place of the creditor to whose rights he or she succeeds in relation to the debt, and gives to the substitute all the rights, priorities, remedies, liens, and securities of the person for whom he or she is substituted." 16 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3D* § 222:5 (2000). Thus, the rights of the plan to its participant's claims arise the moment the Plan pays injury-related benefits. The rights of the Plan to settlement moneys sufficient to satisfy its subrogation interest attach the moment such funds come into existence. As stated by *Couch*:

> The right of a subrogated insurer extends to any fund against which the insured had a right to proceed in order to satisfy his or her claim had he or she not been paid by the insurer, and an insurer entitled to subrogation is entitled to have any money received by the insured or his or her attorney which represents payment on the claim to which the insurer has been subrogated held for the use and benefit of the insurer.
>
> If not, the insurer has the right to trace the fund and recover it from whomever holds it . . . .

Id. § 223:89 (footnotes omitted). In the instant case, Janette Knudson holds settlement funds received in satisfaction of claims to which Great-West is subrogated. These funds properly belong to Great-West and are held by Janette Knudson for the use and benefit of Great-West. In retaining these funds, Janette Knudson is unjustly enriched.

Both restitution and the imposition of a constructive trust are available to plans to prevent unjust enrichment and to protect subrogation and reimbursement rights. Although both of these equitable remedies would result in the payment of money to Great-West, these remedies are still equitable remedies. *See Tull v. United States*, 481 U.S. 412 (1987) (disgorgement of improper profits is equitable remedy); *Curtis v. Loether*, 415 U.S. 189 (1974) (back pay is a form of equitable restitution).

Restitution is an equitable remedy which restores something of value to the rightful owner and prevents a person from being unjustly enriched. *See Black's Law Dictionary* 910 (6th ed. 1991); Restatement of Restitution § 1 (1937). In the instant case; the remedy of restitution requires that Janette Knudson return to Great-West those funds to which Great-West is entitled. Absent restitution, Janette Knudson remains unjustly enriched.

The imposition of a constructive trust is also an appropriate equitable remedy here. A constructive trust imposes upon a person the equitable duty to convey property to another on the ground that retention of the property would be wrongful and would unjustly enrich such person. Restatement (Second) of Trusts § 1 cmt. e (1959); Restatement of Restitution § 160 (1937). The effect of a constructive trust prevents a loss to the plan and a corresponding unjust gain to the plan beneficiary. Restatement of Restitution § 160 cmt. d (1937).

Contrary to the rule in the Ninth Circuit, a constructive trust is not based on actual wrongdoing but on equity and fairness. *See Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 251 (2000). Moreover, even if such wrongdoing is a prerequisite for the imposition of a constructive trust, such wrongdoing is present here. Janette Knudson's retention of that portion of settlement funds sufficient to satisfy Great-West's subrogation and reimbursement rights is wrongful, in violation of plan terms and ERISA, and unjustly enriches her. Janette Knudson has asserted control over funds which properly belong to Great-West under plan terms. The imposition of a constructive trust over these funds constitutes "appropriate equitable relief" under ERISA.

IV. CONCLUSION

The decision of the Ninth Circuit Court of Appeals in this case is directly at odds with the goals of Congress in enacting ERISA. If permitted to stand, that decision will subject employee benefit plans to non-uniform regulation and enforcement. The consequent increased administrative expense and decreased subrogation recoveries will result in a loss of benefits for plan beneficiaries. Plan fiduciaries will be denied the uniform enforcement mechanism needed to enforce plan terms and redress violations of plan terms. Moreover, that decision conflicts with decisions of this Court and is clearly incorrect. Equitable relief in the form of specific performance, restitution, and constructive trust is available to plan fiduciaries suing plan beneficiaries in order to enforce plan terms and redress violations of plan terms. For the reasons stated above, Central States, Southeast and

Southwest Areas Health and Welfare Fund respectively requests this Honorable Court to overturn the decision of the Court of Appeals for the Ninth Circuit in this case.

May 3, 2001

Respectfully submitted,

WILLIAM J. NELLIS
Secretary to the Board
of Trustees
Central States, Southeast
and Southwest Areas
Health and Welfare Fund
9377 W. Higgins Road
Rosemont, Illinois 60018
(847) 518-9800

JOHN A. KUKANKOS
Counsel of Record
JAMES L. COGHLAN
FRANCIS E. STEPNOWSKI
DEBRA M. CYRANOSKI
COGHLAN KUKANKOS COOK
One N. Franklin Street
Suite 900
Chicago, Illinois 60606
(312) 357-9200

Attorneys for Amicus Curiae

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IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES & DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, THE BLUE CROSS BLUE SHIELD ASSOCIATION, THE CHAMBER OF COMMERCE OF THE UNITED STATES, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* AND BRIEF OF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

STEPHANIE W. KANWIT
Counsel of Record
KATHLEEN A. PETERSON
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, N.W., Suite 700
Washington, D.C. 20037
(202) 861-0900

Attorneys for Amici Curiae

(additional counsel listed on inside cover)

166883

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

41PP

LOUIS SACCOCCIO
AMERICAN ASSOCIATION
OF HEALTH PLANS
1129 20th Street, N.W.
Suite 600
Washington, D.C. 20036
(202) 778-3210

LYNN DUDLEY
AMERICAN BENEFITS COUNCIL
1212 New York Avenue, N.W.
Suite 1250
Washington, D.C. 20005
(202) 289-6700

ROGER G. WILSON
BLUE CROSS BLUE SHIELD ASSOCIATION
225 North Michigan Avenue
Chicago, IL 60601
(312) 297-6000

ROBIN S. CONRAD
JOSHUA A. ULMAN
NATIONAL CHAMBER LITIGATION
CENTER, INC.
Counsel for the Chamber of Commerce of the United States
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

JEFFREY GABARDI
HEALTH INSURANCE ASSOCIATION
OF AMERICA
555 13th Street, N.W.
East Tower
Washington, D.C. 20004
(202) 824-1621

MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE*

Pursuant to Supreme Court Rule 37, the American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America respectfully move this Court to grant them leave to file a brief *amici curiae* in support of Petitioners Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Benefit Plan for Employees and Dependents of Earth Systems, Inc. The *Amici* submit their brief *amici curiae* together with this motion. In support, *Amici* state:

1. Consent of all parties has been requested. Petitioners have consented to the filing of this brief, but Respondents have not. Petitioners' letter of consent accompanies this motion for filing with the Clerk of this Court.

2. *Amicus* the American Association of Health Plans (AAHP) is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 health plans serving more than 140 million Americans, the majority of whom are participants or beneficiaries of employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).[1]

---

1. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001 *et seq.*).

3. *Amicus* the American Benefits Council is an organization that advocates for voluntary private employee benefits. Its members sponsor, administer, or service health, retirement and stock compensation plans covering more than 100 million Americans.

4. *Amicus* the Blue Cross Blue Shield Association comprises forty-five independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide health care coverage to private and public employees and individuals, through relationships with employers, employee benefits plans, and direct contracts with subscribers. They offer health insurance, fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross Blue Shield companies furnish health care coverage to 78 million — or one in four — Americans, making them collectively the largest entity offering health insurance and benefits in the United States.

5. *Amicus* the Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations with 140,000 direct members of every size, in every business sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of concern to the American business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, the employees' dependents, and to the Chamber.

6. *Amicus* the Health Insurance Association of America (HIAA) is a national association of private health insurance companies and an advocate for the private, market-based insurance system. HIAA's more than 294 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to approximately 123 million Americans.

7. *Amici* are concerned by the Ninth Circuit's holding in the case below, which essentially vitiates reimbursement provisions that are commonly included in employee health benefit plans which are offered by their member organizations, or which they insure or administer. The Ninth Circuit's holding runs contrary to ERISA's mandate that a fiduciary administer an ERISA plan "in accordance with the documents and instruments governing the plan." It also interferes with nationally uniform plan administration by making plans subject to different legal obligations in different federal circuits and by subjecting plans to varying state laws, undermining the carefully balanced congressional scheme and increasing compliance costs. Most critically in a time of tight healthcare budgets, it will have a drastically adverse effect on the ability of the employee benefit plan community and the health care industry to provide quality care at an affordable cost.

8. In filing this brief, *Amici* seek to bring to the attention of this Court relevant matters not already brought to its attention by the parties, including but not limited to the disastrous

national impact of the lower court's decision on the health insurance and employee welfare benefit plan industry at large.

For the above reasons, *Amici* respectfully request this Court to grant leave to file their brief *amici curiae*.

Respectfully submitted,

STEPHANIE W. KANWIT
Counsel of Record
KATHLEEN A. PETERSON
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, N.W., Suite 700
Washington, D.C. 20037
(202) 861-0900

LOUIS SACCOCCIO
AMERICAN ASSOCIATION
OF HEALTH PLANS
1129 20th Street, N.W.
Suite 600
Washington, D.C. 20036
(202) 778-3210

LYNN DUDLEY
AMERICAN BENEFITS COUNCIL
1212 New York Avenue, N.W.
Suite 1250
Washington, D.C. 20005
(202) 289-6700

ROGER G. WILSON
BLUE CROSS BLUE SHIELD
ASSOCIATION
225 North Michigan Avenue
Chicago, IL 60601
(312) 297-6000

ROBIN S. CONRAD
JOSHUA A. ULMAN
NATIONAL CHAMBER LITIGATION
CENTER, INC.
Counsel for the Chamber of Commerce of the United States
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

JEFFREY GABARDI
HEALTH INSURANCE ASSOCIATION
OF AMERICA
555 13th Street, N.W.
East Tower
Washington, D.C. 20004
(202) 824-1621

Attorneys for Amici Curiae

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BRIEF OF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

I. STATEMENT OF INTEREST[1]

The American Association of Health Plans (AAHP) is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 health plans serving more than 140 million Americans, the majority of whom are participants or beneficiaries of employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).[2]

The American Benefits Council is an organization that advocates for voluntary private employee benefits. Its members sponsor, administer, or service health, retirement and stock compensation plans covering more than 100 million Americans.

The Blue Cross Blue Shield Association comprises forty-five independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide health care coverage to private and public employees and individuals, through relationships with employers, employee benefits plans, and direct contracts with subscribers. They offer health insurance, fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross Blue Shield companies furnish health care coverage to 78 million — or one in four — Americans, making them collectively the largest entity offering health insurance and benefits in the United States.

1. Counsel for *Amici* were the sole authors of this brief. No person or entity other than *Amici* made financial contribution to this brief.

2. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001 *et seq.*).

The Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations with 140,000 direct members of every size, in every business sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of concern to the American business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital important to them, their employees, the employees' dependents, and to the Chamber.

The Health Insurance Association of America (HIAA) is a national association of private health insurance companies and an advocate for the private, market-based insurance system. HIAA's more than 294 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to approximately 123 million Americans.

Amici are concerned by the Ninth Circuit's holding in the case below, which essentially vitiates reimbursement provisions that are commonly included in employee health benefit plans which are offered, insured, or administered by their member organizations. Petitioners have consented to *Amici* filing this brief but Respondents have not. The Court of Appeals erred in holding that the reimbursement of payments made to an ERISA plan beneficiary did not constitute "appropriate equitable relief" within the meaning of ERISA Section 502(a)(3). The Petitioners here properly sought to rely on that Section, which allows actions "(A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief:

(i) to redress such violations; or (ii) to enforce any provisions . . . or the terms of the plan."[3]

In preventing an ERISA fiduciary from obtaining reimbursement out of a tort recovery of medical expenses that the plan has paid on behalf of a participant or beneficiary, the lower court has in effect nullified a critical plan provision by judicial fiat. Its holding has the following adverse effects:

- It allows noncompliant participants or beneficiaries to be unjustly enriched at the expense of their fellow participants and beneficiaries;
- It disincentivizes employers from sponsoring and funding employee benefit plans;
- It interferes with nationally uniform plan administration by making health benefit plans subject to different legal obligations in different federal circuits; and
- It forces a fiduciary to contravene ERISA's mandate that a plan be administered in accordance with plan documents.[4]

Because health plans recoup significant amounts of money under reimbursement provisions, the Ninth Circuit's decision will drastically and adversely affect the ability of the employee benefit plan community and the health care industry to provide, administer, fund and arrange for appropriate and affordable care in a time of rising health care costs. This country's health care financing system depends on effective cost-containment practices, including reimbursement provisions, to ensure the wise use of limited health care dollars and to ensure employers' economic support of employee benefit plans.

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3. Employee Retirement Income Security Act of 1974 (ERISA) § 502(a)(3), 29 U.S.C. § 1132(a)(3) (1994).

4. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

II. SUMMARY OF ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

In the case below, the Ninth Circuit essentially held that a beneficiary did not have to reimburse her employee health benefit plan for expenses provided her from a third party recovery, despite an explicit reimbursement clause in the plan documents mandating such reimbursement. Adopting an aberrational construction of equitable relief, the court held that the enforcement of such reimbursement provisions necessarily constituted "legal" damages rather than "equitable" relief within the meaning of ERISA Section 502(a)(3)(B).[5] Not only is there no precedent to support the Ninth Circuit's novel interpretation of what constitutes "equitable" relief, but the precedent of this Court is directly contrary.[6] Moreover, no other federal circuit court espoused such a rigid definition of equitable relief, and in fact all other circuits which have considered the issue have explicitly rejected the underlying reasoning.[7]

5. *Great-West Life & Annuity Ins. Co. v. Knudson*, No. 98-56472, 2000 WL 145374 at *1 (9th Cir. Feb. 7, 2000) (citing ERISA § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B)).

6. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (finding appropriate "equitable relief" as used in Section 502(a)(3) means "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)"); *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 252-53 (2000) (equitable remedy of constructive trust could be applied to recover money for a plan from a party); *Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990) (refusing to hold that "any award of monetary relief must *necessarily* be 'legal relief'", and noting that damages can be equitable "where they are restitutionary" (citing *Curtis v. Loether*, 415 U.S. 189, 196 (1974)) (further citations omitted)).

7. *See Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 401 (7th Cir. 2000); *Administrative Comm. v.* (Cont'd)

By writing out of the statute the ability of fiduciaries to use Section 502(a)(3) to enforce plan reimbursement clauses, the Ninth Circuit's holding leaves fiduciaries in a bind, with no alternative remedies either under ERISA or under state law. No other provision of ERISA can be construed to provide the necessary relief to a plan whose reimbursement clause is rendered a nullity. Moreover, because ERISA provides that federal courts shall have exclusive jurisdiction over enforcement of plan terms, plans have no alternative forum, as they cannot enforce their reimbursement rights in the state courts.[8]

In essence, the Ninth Circuit's holding does violence to the text of ERISA in that it: (1) bars fiduciaries from seeking relief under ERISA Section 502(a)(3), contrary to the statute's specific language; and (2) contravenes ERISA's Section 404(a)(1)(D) requirement that an employee benefit plan be administered in accordance with its governing documents.

Not only is the lower court's interpretation contrary to the language of the statute, but it contravenes *every one* of

(Cont'd)
Gauf, 188 F.3d 767, 770-71 (7th Cir. 1999); *Health Care Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 711 (7th Cir. 2000); *Southern Council of Indus. Workers v. Ford*, 83 F.3d 966, 969 (8th Cir. 1996) (per curiam); *Blue Cross & Blue Shield v. Sanders*, 138 F.3d 1347, 1352-53 n.5 (11th Cir. 1998).

8. *See, e.g., Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr. 2d 723 (Ct. App. 1996) (finding plan's state court reimbursement claims preempted by ERISA); *see also Carpenters Health v. McCracken*, 100 Cal. Rptr. 2d 473, 476 (Ct. App. 2000) ("Taken together, *Krafka* and [*FMC Medical Plan v.*] *Owens* [122 F.3d 1258 (9th Cir. 1997)] place a plaintiff seeking reimbursement under the terms of an employee benefit plan in a Catch 22. Under *Krafka*, the plaintiff must pursue its reimbursement claim in federal court. Under *Owens*, by contrast, the plaintiff must pursue its reimbursement claim in state court.").

what this Court has called the sometimes "competing congressional purposes" for enacting ERISA in the first place.[9] Those purposes include the desire to: (1) protect plan participants and beneficiaries,[10] (2) assure uniformity and efficiency in plan administration,[11] and (3) create incentives for the creation and maintenance of employee benefit plans.[12] As outlined below, every one of those congressional goals would be frustrated here by allowing the lower court decision to stand.

In sum, the Ninth Circuit's decision: (1) hinders plan sponsors, plan fiduciaries, and managed care organizations from including reimbursement provisions in their contracts, thereby implementing legitimate and necessary strategies to prevent the unnecessary dissipation of a limited pool of health care funds; (2) allows plan participants and beneficiaries to

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9. *Varity Corp. v. Howe*, 516 U.S. 489, 507 (1996).

10. *See Boggs v. Boggs*, 520 U.S. 833, 845 (1997) ("The principal object of the statute is to protect plan participants and beneficiaries.") (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)). The statute itself notes that the express purpose is "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b).

11. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

12. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) ("A patchwork scheme of regulation would introduce considerable inefficiencies in the benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Additionally, the U.S. Internal Revenue Code provides incentives both for employers to establish qualified benefit plans as well as for employees to participate in them, because a contribution to a qualified plan is immediately deductible by the employer and only becomes taxable to the employee on subsequent distribution. I.R.C. § 404.

collect windfall payments at the expense of the majority of their co-participants in the same benefit plan; (3) creates an administrative burden for plan administrators and increases costs and delays by requiring them to follow different reimbursement provisions depending on the circuit; and (4) ultimately will lead to increases in health benefit plan costs, discouraging employers and others from maintaining benefit plans, and inevitably increasing the ranks of the uninsured.

III. ARGUMENT

A. Reimbursement Provisions Are Critical Cost Saving Measures Designed to Benefit All Plan Participants and Beneficiaries

1. Reimbursement Provisions Ensure That Health Coverage Remains Affordable

Reimbursement provisions such as those at issue in this case are used extensively throughout the insurance and managed care industries, and have been in continuous use since the passage of ERISA. Such provisions generally require a plan participant or beneficiary to reimburse the plan for funds expended on the beneficiary's behalf, if the beneficiary recoups money from a third party responsible for the beneficiary's injuries.

Reimbursement provisions serve several important goals, including: (1) preventing participants and beneficiaries from retaining double recoveries and thus conserving limited plan funds; (2) preventing responsible parties such as tortfeasors from profiting from the existence of participants' and beneficiaries' health care cove~~rage~~; and (3) limiting the age-old moral hazard problem, whereby participants and

beneficiaries alter their behavior because of the presence of insurance or other coverage.[13]

Functionally, reimbursement provisions operate to allow insurance companies and health benefit plans to recoup funds directly from participants or beneficiaries who ultimately recover payments for the same injuries from responsible third parties. Reimbursement differs from the more expensive alternative of subrogation, in that under a reimbursement provision, a health benefit plan does not actually commence an action in the beneficiary's name, as it would under a subrogation provision, but instead acts as a first lienholder upon any third-party funds collected by the beneficiary.

Private insurers have been relying on reimbursement mechanisms since at least the mid-eighteenth century to ensure that coverage remains accessible and affordable for all.[14] Such provisions are also utilized by public payors. For example, the federal Medicare Secondary Payor provisions require Medicare beneficiaries to reimburse Medicare for expenses later paid by liability insurance or automobile

13. The moral hazard concern is particularly at issue in this case, where the Respondent Ms. Knudson settled the prior medical expense portion of her original claims for only $13,828.70, knowing that Petitioners had covered her medical expenses which amounted to in excess of $400,000.

14. *See* M. L. Marasinghe, *An Historical Introduction to the Doctrine of Subrogation: The Early History of the Doctrine I*, 10 VAL. U.L. REV. 45 (1975); *see also Randal v. Cockran*, 1 Ves. Sen. 98, 27 Eng. Rep. 916 (Ch. 1748) (Lord Hardwicke finding "the plainest equity that could be" where "[t]he person originally sustaining that loss was the owner, but after satisfaction made to him, the insurer. No doubt, but from that time, as to the goods themselves, if restored in *specie, or compensation made for them*, the assured stands as a trustee for the insurer, in proportion for what he paid." (emphasis added)).

insurance.[15] Any Medicare payment made with respect to any item or service for which payment has been made, or can reasonably be expected to be made promptly by a third party payor, is conditioned on reimbursement to the appropriate Trust Fund. With very limited exceptions, this provision allows Medicare to recover fully and directly from beneficiaries for liabilities paid by third party payors, without regard to whether the beneficiaries accepted discounted settlements.[16]

2. Plan Fiduciaries and Administrators Are Obligated to Employ Reimbursement Provisions to Conserve Limited Plan Assets

Reimbursement provisions are critical cost-savings devices for employers and other plan sponsors facing strong health care cost inflation pressures. As this Court explicitly recognized in *Pegram v. Herdrich*,[17] systems for the achievement of cost savings in health care coverage and delivery have constituted a key part of federal and state health care programs since the passage of the Federal Health Maintenance Organization Act of 1973,[18] and indeed Congress has legislated since that time in the area of cost-containment mechanisms.[19]

15. *See* 42 U.S.C. § 1395y(b)(2)(B) (1994 & Supp. V 2000).

16. *See* 42 C.F.R. § 411.35 (2000); *Zinman v. Shalala*, 67 F.3d 841, 845 (9th Cir. 1995) (holding that the Medicare Secondary Payor provisions allow the U.S. Department of Health and Human Services to recover full reimbursement of conditional Medicare payments from beneficiaries, even though the beneficiaries received discounted settlements from third parties).

17. 530 U.S. 211, 233 (2000).

18. 42 U.S.C. § 300(e).

19. *See, e.g.*, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2945, (codified as amended at 42 U.S.C. § 1301 *et seq.*), which limited the use of pre-existing condition exclusions.

Millions and potentially billions of dollars are recouped annually by health plans and insurers by virtue of subrogation and other recovery mechanisms.[20] Reimbursement provisions are designed to protect *all* beneficiaries' interests by ensuring that plan funds are used prudently, and, in the words of the statute, for the "exclusive purpose of . . . providing benefits to participants and their beneficiaries; and . . . defraying reasonable expenses of administering the plan."[21]

ERISA and the law of trusts[22] require plan fiduciaries to manage the assets of their health plans prudently and in the best interests of all beneficiaries,[23] and "to act to ensure that a plan receives all funds to which it is entitled, so that those funds can be used on behalf of participants and beneficiaries."[24] The statute uses the plural deliberately — the interests of those plan members in the aggregate are paramount, and one member should not be allowed to benefit disproportionately at the expense of the group. In fact, each of those trust beneficiaries owe each other a fiduciary duty not to take advantage of the others.[25]

20. During fiscal year 2000, Healthcare Recoveries, Inc., one of the largest private health care claims recovery services in the United States, recovered $237.3 million in health claims, and had a backlog of over $1.1 billion of potentially recoverable claims. *See* Healthcare Recoveries, Inc., Form 10-K, for the fiscal year ended Dec. 31, 2000, at 20.

21. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A).

22. This Court has held that the common law of trusts is incorporated in ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3). *See Harris Trust & Sav. Bank*, 530 U.S. at 250.

23. ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B).

24. *See Central States Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 571 (1985).

25. *See* GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 191 (rev. 2d ed. 1979); RESTATEMENT (SECOND) OF TRUSTS §§ 251-255 (1959).

The lower court's holding, however, erects an insurmountable roadblock, preventing ERISA plan fiduciaries from complying with their duty to be financially prudent and seek recovery of plan funds where available.[26] It also allows a few ERISA beneficiaries to be unjustly enriched at the expense of their fellow plan beneficiaries.

3. The Ninth Circuit's Decision Will Inevitably Increase Health Benefit Costs and Increase the Ranks of the Uninsured

The Ninth Circuit's holding rendering health plan reimbursement provisions a nullity and precluding employee health benefit plans from recovering from third-party payments necessarily drains plan funds. Health benefit plans can be insured either through a risk-bearing mechanism or self-insured, and hence reliant on employer assets to pay charges for health care, as was Ms. Knudson's plan.[27] In either case, they must charge premiums commensurate with that risk, or adequate to ensure that funds will be available for services needed by employees and their dependents.[28]

Insurance companies and employee health benefit plans base rates and benefit levels on actuarial determinations that factor in the effect of subrogation and reimbursement provision recoveries.[29] Should plans be barred from seeking

26. *See Varity Corp.*, 516 U.S. at 514; *Liss v. Smith*, 991 F. Supp. 278, 290 (S.D.N.Y. 1998).

27. As this Court summarized in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985), employee welfare plans "may self-insure or they may purchase insurance for their participants."

28. *See* SHERYL TATAR DASCO & CLIFFORD C. DASCO, MANAGED CARE ANSWER BOOK 3-40 (3d ed. 1999).

29. *See e.g.* DOCUMENTATION IN HEALTH BENEFIT PLAN RATEMAKING, Actuarial Standards of Practice No. 31, § 3.5.4 (Actuarial Standards Bd. 1997).

reimbursement from members that have been doubly indemnified for their damages, those actuarial assumptions are rendered invalid. That loss of predictability makes rate-setting difficult or impossible, and, when combined with the inability to recoup plan funds, the inevitable result will be that rates will ultimately increase and/or benefits will decrease for all members of employee health benefit plans.

After a period of relatively stable health care costs, employers are once again facing health care inflation. Such inflation is attributable to a variety of factors, including changes in medical practice, the development of expensive new technologies, and greater use of prescription drugs and other services.[30] To cope with those rising costs, employers are working with insurers and health plans[31] to control health care costs[32] through the management of health care, including the use of cost containment mechanisms such as reimbursement.

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30. *See Hearing on the Relationship Between Health Care Costs and America's Uninsured Before the Subcomm. on Employer-Employee Relations of the House Comm. on Educ. & the Workforce*, 106th Cong. 55, 60 (statement of Dan Crippen, Director, Congressional Budget Office) [hereinafter *Hearings*]. *See generally* HEALTH INS. ASS'N OF AM., ISSUE BRIEF: WHY DO HEALTH INSURANCE PREMIUMS RISE? (2000).

31. *See Hearings*, *supra* note 30, at 58-59; HEALTH INS. ASS'N OF AM., *supra* note 30, at 18-19.

32. *See generally* Jack Zwanziger & Glenn A. Melnick, *Can Managed Care Plans Control Health Care Costs?*, HEALTH AFFAIRS, Summer 1996, at 185, 196 (concluding that "the failure of governmental health care reform leaves the primary responsibility of increasing the efficiency of the health care system to the private sector. The studies summarized [in this article] strongly suggest that managed care plans have been successful in inducing price competition and forcing costs down.").

According to the Mercer/Foster Higgins annual *National Survey of Employer-Sponsored Health Plans*, costs of employee health benefit plans increased 8.1% during calendar year 2000, more than twice the rate of general inflation.[33] Similarly, the Kaiser Family Foundation and the Health Research and Educational Trust determined that employee health benefit plan and insurance premiums increased 8.3% from the Spring of 1999 to the Spring of 2000, outpacing the inflation rate by more than 5%,[34] and a survey by the Towers Perrin consulting firm found that cost increases for employee health benefit plans in 2000 averaged 10%, compared to inflation of only 3.4%.[35]

The costs of employee health benefit plans are projected to again increase significantly during 2001. Mercer/Foster Higgins projects that average cost increases in employee health benefit plans will be 11%,[36] and the Washington Business Group on Health and Watson Wyatt Worldwide projects average increases of 12.2%.[37]

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33. William M. Mercer, Inc., *Employers Bracing for Double-Digit Health Benefit Cost Rise in 2001*, MERCER REP., Jan. 12. 2001, at 1, 1 (summarizing survey results from the William M. Mercer, Inc. & Foster Higgins, *National Survey of Employer-Sponsored Health Plans 2000*. Over 3,300 employers responded to the Mercer/Foster Higgins survey, and the results are statistically projectable to all U.S. employers that employ ten or more employees and offer health benefits).

34. KAISER FAMILY FOUND. (KFF) & HEALTH RESEARCH & EDUC. TRUST (HRET), EMPLOYER HEALTH BENEFITS, 2000 ANNUAL SURVEY 12 (2000). The survey found that the inflation rate during this time was 3.0%.

35. TOWERS PERRIN, 2001 HEALTH CARE COST SURVEY, REPORT OF KEY FINDINGS 5 (2001) (221 employers responded to the Towers Perrin survey).

36. William M. Mercer, Inc., *supra* note 33, at 1.

37. WASHINGTON BUSINESS GROUP ON HEALTH & WATSON WYATT WORLDWIDE, HEALTH CARE COSTS 2001 2 (2001).

As costs rise, employers must necessarily limit benefits, limit or even end their support of health and welfare plans, or pass cost increases on to employees. None of those results are optimal at a time when an estimated 43 million Americans are uninsured.[38] Cost containment mechanisms such as reimbursement provisions are critical to ensure that the number of privately insured individuals does not decrease.[39] Studies have shown that employers and health care beneficiaries are highly price sensitive,[40] and increasing the cost of health care coverage will ultimately lead to a corresponding decrease in the number of covered individuals.[41] Even a one percent increase in managed care plans' costs nationally "results in a potential loss of insurance coverage for about 315,000 individuals" over a five-year period.[42] The Ninth Circuit's decision to disallow enforcement of reimbursement provisions in ERISA plans will force the price of coverage up, and ultimately cause more Americans to be uninsured.

Employer-based health insurance is the keystone of the American health care system. In 1999, over 70% of people in the United States had some kind of private health coverage[43] and over 60% of that coverage was employer-

38. *See* ROBERT J. MILLS, CENSUS BUREAU, U.S. DEP'T OF COMMERCE, P60-211, CURRENT POPULATION REPORTS: HEALTH INSURANCE COVERAGE 1999 1 (2000).

39. *See Hearings*, *supra* note 30, at 63.

40. *See* Zwanziger & Melnick, *supra* note 32, at 190-91.

41. *See id.*; KFF & HRET, *supra* note 34, at 164; HEALTH ECON. PRACTICE GROUP, BARENTS GROUP, LLC, IMPACTS OF FOUR LEGISLATIVE PROVISIONS ON MANAGED CARE CONSUMERS: 1999–2003 iii (prepared for the Am. Ass'n of Health Plans, 1998); *Hearings*, *supra* note 30, at 62-63.

42. *See* HEALTH ECON. PRACTICE GROUP *supra* note 41, at iii.

43. *See* MILLS, *supra* note 38, at 3.

based.[44] As the number of privately insured individuals decreases, the financial burden of health care may shift to the already-strained federal and state systems.[45] National public policy is clearly against altering the health insurance and ERISA plan industry in any way that would significantly increase premium and deductible rates. The Ninth Circuit's decision below, in shifting to plan participants the burden of the medical expenses caused by a tortfeasor who had insured himself against just such a contingency, serves no clear public policy purpose.

B. The Ninth Circuit's Holding Contravenes Every One of ERISA's Purposes

1. The Ninth Circuit's Decision Harms Plan Participants and Beneficiaries.

Should the Ninth Circuit believe that it is helping individual plan participants or beneficiaries retain additional monies by invalidating reimbursement clauses, it could not be more wrong. In fact, a plan's enforcement of its reimbursement clause simultaneously serves the interest of both the plan and the beneficiary, unlike the more common situation where there is "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing . . . costs."[46]

44. *See id.* at 1.

45. *See* JOHN SHEILS & LISA ALECXIH, LEWIN GROUP, INC., RECENT TRENDS IN EMPLOYER HEALTH INSURANCE COVERAGE AND BENEFITS, FINAL REPORT 7 (1996) (projecting that as the percentage of people with employer-sponsored health care as their primary health care coverage decreases, the percentage of people with Medicare or Medicaid as their primary source of health care coverage will increase).

46. *Mertens*, 508 U.S. at 262-263 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981)).

When operational, reimbursement provisions prevent double payment for the same claim, and ensure that the liability for tort claims fall on those who cause injury rather than innocent plan beneficiaries.[47] The Ninth Circuit's decision potentially penalizes Ms. Knudson's fellow beneficiaries in at least three ways: (1) other group beneficiaries might choose to ignore plan language and their reimbursement obligation on a selective basis, as Ms. Knudson did; (2) premiums or contributions to the health benefit plan may rise, as the need arises to make up the shortfalls paid out to Ms. Knudson and others like her; and (3) the employer sponsor may decide to either cut back its contribution (again, requiring an increase in premiums) or eliminate the health benefit plan altogether.[48]

Barring enforcement of a plan reimbursement provision constitutes unjust enrichment of one participant or beneficiary at the expense of the group. Individuals, their family members, and their fellow co-workers may be subjected to a scenario where too few resources exist for health care expenses at a later date, or, in the extreme case, where an employer may decide to limit benefits or cancel its sponsorship of a benefit plan altogether.

In health care, as in all other aspects of the economy, the pool of dollars is necessarily limited, and a windfall to one plan member must inexorably come out of the pockets of the rest, either directly through higher premiums,

47. *See Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 712.

48. *See Hearings*, *supra* note 30, at 62-63 (stating that employers would respond to increased costs by being less generous with coverage, raising cost-sharing requirements, or even eliminating benefits or dropping coverage completely. Employees would respond to rising health insurance costs by dropping coverage as premiums increase, or selecting less generous coverage.).

deductibles, and copays, or indirectly through reduced benefits. In sum, upholding the Ninth Circuit's *Knudson* decision will serve to pit plan beneficiaries against each other, and defeat, rather than advance the congressional goal of protecting "the interests of participants in employee benefit plans and their beneficiaries."[49]

2. The Invalidation of Plan Reimbursement Provisions Creates Disincentives to Employer Funding of Benefit Plans

Sustaining the holding of the Ninth Circuit with respect to health benefit plan reimbursement provisions will considerably reduce the incentives of plan sponsors such as employers to sponsor and/or fund health care for their employees, and increase costs for them and ultimately the plan participants as well. This Court has been adamant that ERISA not be interpreted in a manner which "create[s] a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit benefits in the first place."[50]

There is no legal mandate to sponsor such plans, nor is there any mandate regarding "what kind of benefits employers must provide if they choose to have such a plan."[51] Instead, employers voluntarily support this nation's employer-based private health care coverage system.[52] Such employer-sponsored plans are critical: of all individuals

49. 29 U.S.C. § 1001(b); *see Boggs*, 520 U.S. at 845 ("The principal object of the statute is to protect plan participants and beneficiaries").

50. *Varity Corp.*, 516 U.S. at 497.

51. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996).

52. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

living in families headed by a worker, 68% live in households where the family head receives coverage through an employer.[53] Among such households, 88% of individuals receive employment-based coverage.[54]

In the case of Ms. Knudson, her medical bills were advanced to her by the Petitioners pursuant to the agreement that the self-funded plan would have the first lien and be reimbursed out of any tort recovery. The holding below will inevitably and materially increase premium costs for those employers willing to sponsor ERISA plans, and those costs will likely be passed on to their employees and those who purchase their products and services.[55]

3. The Ninth Circuit's Decision Prevents Uniform Administration of Multistate Employee Benefit Plans

The Ninth Circuit's position on the nonenforceability of reimbursement clauses is unique: it is contrary to the position of every other federal circuit that reimbursement provisions are enforceable equitable relief under ERISA.[56] Only ERISA plan participants litigating in that particular circuit are entitled to disregard plan contractual language and recover more than they are entitled to, while participants in every other circuit are bound by the reimbursement terms of their plans.

53. *See* William S. Custer & Pat Ketsche, Center for Risk Mgmt. & Ins. Research, Georgia State Univ., Employment-Based Health Insurance Coverage 7 (Health Ins. Ass'n of America, 2000).

54. *See id.*

55. *See* William M. Mercer, Inc., *supra* note 33, at 1.

56. *See, e.g.*, *Wal-Mart Stores, Inc.*, 213 F.3d at 401; *Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 710; *Blue Cross & Blue Shield*, 138 F.3d at 1352-53 n.5; *Southern Council of Indus. Workers*, 83 F.3d at 969; *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615-16 (7th Cir. 1995).

Vitiating such reimbursement provisions in one circuit and one circuit only disrupts any federal attempt at uniform plan regulation.[57] ERISA was intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," and thus "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government."[58] Clearly, denying ERISA plans in the Ninth Circuit the right to enforce reimbursement provisions under Section 502(a), 29 U.S.C. § 1132(a), results in the complete abrogation of their rights in one particular area of the country and hence non-uniform enforcement.

Like the state statute revoking the designation of a spouse as life insurance beneficiary automatically upon divorce which was struck down by this Court recently in *Egelhoff v. Egelhoff*, the Ninth Circuit's holding impacts "a central matter of plan administration."[59] That "central matter" pertains to the essence of health coverage: both the ability to access it subsequent to an accident that results in medical bills, and the ability to afford it both now and in the long run. Thus, a beneficiary may find that the plan has not advanced medical expenses because of the impossibility of recovery of those expenses out of an ensuing tort settlement. Or a plan may find that it is unfortunately enmeshed in expensive litigation instead of the simple automatic lien on recovery called for in the plan documents — costs that

57. *See FMC Corp. v. Holliday*, 498 U.S. 52, 58-60 (1990).

58. *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 656 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)); *see Egelhoff v. Egelhoff*, No. 99-1529, slip op. at 6-7 (U.S. Mar. 21, 2001) ("Uniformity is impossible, however, if plans are subject to different legal obligations in different States."); *Fort Halifax Packing Co.*, 482 U.S. at 9; *see also Shaw*, 463 U.S. at 99.

59. *Egelhoff*, No. 99-1529, slip op. at 6.

inevitably will be passed on to employees and their families in the form of higher premiums. Such litigation ultimately transfers to plan beneficiaries and their families the "costs of delay and uncertainty"[60] that arise from forcing plan administrators to weigh alternate options for recovery, if any, such as pursuing the far more expensive remedy of traditional subrogation.[61]

As in *Egelhoff*, "the burden is exacerbated by the choice-of-law problems that may confront an administrator" when the relevant parties are located in different states.[62] Here, an employer may sponsor a plan from its headquarters in Connecticut, retaining fiduciary responsibilities, while its claims administrator is located in Pennsylvania, and the beneficiary may be from Kansas. Yet if the tort judgment has been rendered in California solely because it was the situs of the automobile accident involving that beneficiary, who was in California on vacation, the Ninth Circuit's peculiar rule applies. The substantial administrative uncertainties created by such a scenario are evident for ERISA plan sponsors, plan fiduciaries, and beneficiaries.

The Ninth Circuit rule may inspire a less than scrupulous beneficiary, moreover, to deliberately choose a venue for filing a tort suit within that Circuit's jurisdiction to take advantage of the "no reimbursement" rule. The federal courts should not encourage plaintiffs to forum shop by allowing plaintiffs to determine the venue of potential tort actions at the expense of their employers and fellow beneficiaries.

60. *Id.* at 7.

61. Subrogation may not be available as a alternative remedy in all situations. For example, many states prohibit health plan subrogation, *see, e.g.*, CONN. GEN. STAT. § 52-225c (2000); GA. CODE. ANN. § 33-24-56.1(e) (2000); VA. CODE. ANN. § 38.2-3405 (Mitchie 2000), and some plans may not provide for subrogation.

62. *Egelhoff*, No. 99-1529, slip op. at 7.

In sum, the lower court's decision "would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators — burdens ultimately borne by the beneficiaries."[63]

C. The Ninth Circuit's Decision Forces a Plan to Violate ERISA's Mandate That a Plan be Administered in Accordance With Its Documents and Instruments

The plan documents at issue in the case below expressly entitled the plan to reimbursement for medical expenses that were paid on behalf of Ms. Knudson.[64] ERISA provides that every employee benefit plan be established pursuant to a written instrument and that named fiduciaries control and manage the operation and administration of the plan.[65] The statute's participant protections attempt to ensure that the appointed plan administrators and fiduciaries implement the plan "in accordance with the documents and instruments governing the plan."[66] Despite the explicit language of the statute that plan fiduciaries must have access to the federal courts to enforce plan terms and redress violations of those plans, the Ninth Circuit has effectively left them without a remedy by denying them access to the federal courts to enforce reimbursement provisions.

In enacting ERISA, Congress did not intend that the federal judiciary substitute its views as to what constitutes appropriate plan design for the judgments of employers and plan sponsors. Yet the Ninth Circuit's decision in this case in fact arrogates to the federal judiciary the power to rewrite

63. *Egelhoff*, slip op. at 7-8 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142).

64. *See* Pet. for Writ of Certiorari at 5.

65. ERISA § 402(a)(1), 29 U.S.C. § 1002(a)(1).

66. *Egelhoff*, No. 99-1529, slip op. at 5; ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

the terms of health benefit plans — to eliminate one particular cost-saving mechanism, namely the reimbursement provision.

It is not for the federal courts to second-guess legislatively-determined health care policy issues, as this Court pointed out in *Pegram v. Herdrich*.[67] Here, the lower court has substituted its views as to appropriate plan design for the collective judgments of Congress as expressed in ERISA, employers, fiduciaries, and plan sponsors. The foundation of the United States' voluntary, employer-based healthcare system is the ability to design benefit plans with cost-containment mechanisms including reimbursement, free of such interference by the courts, yet the Ninth Circuit seeks to undermine this foundation.

Most disturbing is the Ninth Circuit's willingness to disrupt this foundation based on its anything-but-traditional rewriting of the law of equity to find that a claim for monetary relief is automatically a claim for legal damages that cannot be brought under ERISA Section 502(a)(3). That Court, uniquely, has refused to accept the uniform consensus that monetary relief is not necessarily "legal" relief. Other federal circuit courts that have grappled with the question of how to enforce plans' reimbursement provisions have applied equitable remedies to allow employee health benefit plans to be effectively reimbursed under ERISA. Some have chosen to apply a constructive trust remedy in resolving this issue,[68] while others have chosen alternative rubrics such as specific performance.[69] In addition

67. 530 U.S. 211, 235-37 (2000).

68. *See Wal-Mart Stores, Inc.*, 213 F.3d at 401-02; *Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 710-11.

69. The Eleventh Circuit in *Blue Cross & Blue Shield v. Sanders* relied on precedent that "[s]pecific performance is an equitable remedy available when legal remedies are inadequate" and that "'equitable (Cont'd)

to remedies applied by such courts, a variety of other equitable remedies might be available, such as imposing an equitable lien on the beneficiary's tort recovery, or a mandatory injunction directing the beneficiary to sign over the claim.[70]

(Cont'd)
relief' under § 1132(a)(3)(B) includes monetary awards typically available in equity but not compensatory or consequential damages." *Blue Cross & Blue Shield*, 138 F.3d at 1352-53 n.5 (citing *Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 478 (1962)).

70. *See Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 711. Even should this Court choose to find no relief for Petitioners available under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3), *Amici* urge that it find relief available under an alternative cause of action as a matter of federal common law. *See Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 993 (4th Cir. 1990) (recognizing a federal common law of unjust enrichment under ERISA, holding that ERISA Section 403(c)(2)(A), 29 U.S.C. § 1103(c)(2)(A), "indicates a desire to ensure that plan funds are administered equitably and that no one party, *not even plan beneficiaries*, should unjustly profit").

IV. CONCLUSION

Eliminating the capacity of employee benefit plans to be reimbursed for monies expended on behalf of individual plan participants and beneficiaries out of those individuals' third-party recoveries inevitably increases costs for the plans as well as fellow plan members. This creates unfortunate disincentives to the creation of ERISA plans at a time when the United States' voluntary, employer-sponsored health care system is struggling with rising health care costs.

For the above reasons, *Amici* the American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America respectfully request that this Court reverse the decision of the Court of Appeals for the Ninth Circuit.

Respectfully submitted,

STEPHANIE W. KANWIT
Counsel of Record
KATHLEEN A. PETERSON
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, N.W., Suite 700
Washington, D.C. 20037
(202) 861-0900

LOUIS SACCOCCIO
AMERICAN ASSOCIATION
OF HEALTH PLANS
1129 20th Street, N.W.
Suite 600
Washington, D.C. 20036
(202) 778-3210

LYNN DUDLEY
AMERICAN BENEFITS COUNCIL
1212 New York Avenue, N.W.
Suite 1250
Washington, D.C. 20005
(202) 289-6700

ROGER G. WILSON
BLUE CROSS BLUE SHIELD
ASSOCIATION
225 North Michigan Avenue
Chicago, IL 60601
(312) 297-6000

ROBIN S. CONRAD
JOSHUA A. ULMAN
NATIONAL CHAMBER LITIGATION
CENTER, INC.
Counsel for the Chamber of Commerce of the United States
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

JEFFREY GABARDI
HEALTH INSURANCE ASSOCIATION
OF AMERICA
555 13th Street, N.W.
East Tower
Washington, D.C. 20004
(202) 824-1621

Attorneys for Amici Curiae

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No. 99-1786

IN THE
SUPREME COURT OF THE UNITED STATES

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et al.,
Petitioners,

v.

JANETTE AND ERIC KNUDSON,
Respondents.

On Writ of Certiorari To The
United States Court of Appeals
For the Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF NEITHER PARTY

PAULA BRANTNER
NATIONAL EMPLOYMENT LAWYERS ASSOCIATION (NELA)
600 Harrison Street, #535
San Francisco, CA 94107
(415) 227-4655

Counsel for *Amicus Curiae* NELA

MARY ELLEN SIGNORILLE*
AARP FOUNDATION LITIGATION

MELVIN RADOWITZ
AARP

601 E Street, NW
Washington, DC 20049
(202) 434-2060
Counsel for *Amicus Curiae* AARP
*Counsel of Record

22 pp

MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE* OF AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF NEITHER PARTY

AARP and the National Employment Lawyers Association (NELA) move for leave to file the accompanying brief *amici curiae* in support of the position of neither party in the case of *Great-West Life & Annuity Insurance Company v. Knudson*, which is before the Court on a writ of certiorari from the judgment and opinion of the United States Court of Appeals for the Ninth Circuit.

Pursuant to Supreme Court Rule 37.3, consent of the parties to the filing of the brief was sought, in writing, through counsel. Counsel for the petitioner withheld consent, stating in a telephone conversation, that counsel believed that *amici*'s position would be confusing to the Court. Counsel for respondents did not respond.

INTEREST OF AMICI CURIAE

AARP is a nonprofit membership organization of more than 34 million persons age 50 or older dedicated to addressing the needs and interests of older Americans. More than 45% of AARP's members are working, and many receive employer-funded health, pension, disability, and other employee benefits. Through education, advocacy and service, and by promoting independence, dignity and purpose, AARP seeks to enhance the quality of life for all citizens. As a method of promoting independence, AARP attempts to foster the economic security of individuals as they age by seeking to increase the availability, security, equity, and adequacy of public and private pensions, health, disability, and other employee benefits.

The National Employment Lawyers Association (NELA) is a voluntary organization, founded in 1985, of over 3,000 attorneys who specialize in representing individuals in controversies arising out of the workplace. It is the country's only professional membership organization comprised of

lawyers who primarily represent employees in cases involving employment discrimination, employee benefits, wrongful discharge, and other employment-related matters. NELA has devoted itself to supporting precedent-setting litigation affecting the rights of individuals in the workplace.

As part of their advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP and NELA have participated as *amici curiae*, both jointly and singly, in cases involving ERISA § 502(a)(3) before this Court, *see, e.g.*, *Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000) (suits by nonfiduciary parties in interest permitted under § 502(a)(3)); *Pegram v. Herdrich*, 530 U.S. 211 (2000) (physician-owned HMOs may not be sued as fiduciaries under § 502(a)(3)); *Varity Corp. v. Howe*, 516 U.S. 489 (1996) (suits by individual participants permitted under § 502(a)(3)); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) (remedies under § 502(a)(3)), as well as numerous other ERISA cases, including *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001); *Inter-Modal Rail Employees Ass'n v. Atchinson, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510 (1997); and *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997).

AARP's members, NELA members' clients, and other participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, to protect their rights under those plans. ERISA's protections, and the ability to enforce those protections, are of vital concern to older workers and retirees, since the quality of their lives depends heavily upon the security and amount of their employee benefits. *Amici* therefore have a strong and determined interest in the outcome of this case and in ensuring, to the extent possible, that the rights guaranteed by ERISA are fully carried out.

REASONS FOR GRANTING THE MOTION

Once again, the Court is being called upon to address issues arising under ERISA's civil enforcement provisions. ERISA § 502(a), 29 U.S.C. § 1132(a). *See, e.g.*, *Harris Trust & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000); *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985). Although the number of decisions concerning ERISA's civil enforcement provisions pales in comparison with the number of preemption decisions,[1] the scope of these civil enforcement provisions has generated a substantial number of decisions in the courts.

Although the precise legal question presented here is whether a plan states a claim for relief under ERISA § 502(a)(3) to enforce a reimbursement provision in the plan against a participant, the underlying issue is what remedies fall within the term "appropriate equitable relief."[2] Since this Court's decision in *Mertens*, the lower courts have been in a quandary over the scope of remedies falling within the term "appropriate equitable relief."

Some decisions have left participants and beneficiaries with limited or no remedies, even though the relief sought could have been construed as restitution, a constructive trust or unjust enrichment. *See, e.g.*, *Farr v. U.S. West Communications, Inc.*,

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[1] This Court alone has decided over twenty preemption cases including this term's case of *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001).

[2] ERISA § 502(a)(3) authorizes a civil action :

> by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

179 F.3d 1252 (9th Cir. 1999), *cert. denied*, 120 S. Ct. 935 (2000); *Kerr v. Vatterott & Co.*, 184 F.3d 938 (8th Cir. 1999); *Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), *cert. denied*, 120 S. Ct. 170 (1999); *McLeod v. Oregon Lithoprint, Inc.*, 102 F.3d 376 (9th Cir. 1996); *Fraser v. Lintas: Campbell-Ewald*, 56 F.3d 722, 725 (6th Cir. 1995); *Buckley Dement v. Travelers Plan Administrators of Illinois*, 39 F.3d 784 (7th Cir. 1994); *Novak v. Andersen Corp.*, 962 F.2d 757, 760-61 (8th Cir. 1992), *cert. denied*, 113 S. Ct. 2928 (1993).

In contrast, even where circuit courts have granted relief, they have struggled to stay within the analytical framework *Mertens* has established. These courts disagree over the parameters of equitable relief and the characterization of plaintiffs' request for relief. *Compare, e.g., Holmes v. Bethlehem Steel Corp. Pension Plan*, 213 F.3d 124, 131 (3d Cir. 2000) (payment of prejudgement interest was an equitable remedy to remedy a plan's unjust enrichment and use of the participant's money); *Strom v. Goldman, Sachs & Co.*, 202 F.3d 138 (2d Cir. 1999) (monetary relief is available as equitable make-whole relief when it is sought as remedy for a breach of fiduciary duty); *Administrative Committee v. Gauf*, 188 F.3d 767 (7th Cir. 1999) (a fair reading of totality of complaint indicates equitable relief of specific performance and enforcement of contract is being sought); *Health Cost Controls of Illinois v. Washington*, 187 F.3d 703, 710 (7th Cir. 1999) (in *dicta*, stating that restitution is always equitable when it is sought as remedy for a breach of fiduciary duty); *Fotta v. Trustees of the UMW*, 165 F.3d 209, 212-13 (3d Cir. 1998) (same as *Holmes, supra*); *In re: Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 57 F.3d 1255, 1269 (3d Cir. 1995) (restitutionary reimbursement for back benefits is equitable relief); *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615 (7th Cir. 1995) (permitting a suit for reimbursement to proceed, without deciding, which theory, unjust enrichment or restitution to enforce contractual provision, was applicable); *Schwartz v. Gregoire*, 45 F.3d 1017, 1022 (6th Cir. 1995) (back pay is restitutionary because it restores individuals to the position they would have been in; front pay is a substitute for reinstatement, which is always equitable, recognizing that without such a holding, there would

be no remedy for a § 510 violation for retaliatory discharge); *Health Cost Controls v. Skinner*, 44 F.3d 535, 537 (7th Cir. 1995) (reimbursement suit against participant for medical costs recovered against tortfeasor may proceed, recharacterizing requested relief from damages to restitution).

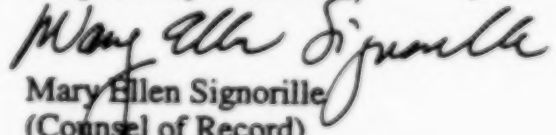
Amici believe that the arguments that they are presenting to the Court are different than those being presented by either party or *amici* represented by Mr. Taranto, thus assisting the Court in its consideration of this case.

Thus, this case presents the Court with the opportunity to revisit its *Mertens* decision, or alternatively, provide guidance on the scope of the term "appropriate equitable relief."

The resolution of this issue is important to AARP members and NELA's members' clients because these individuals need to know their legal obligations if they are sued under ERISA § 502(a)(3), or, conversely, their legal remedies if they themselves sue under that section. Thus, the decision in this case will have a direct and vital bearing on the economic security of older working Americans. In light of the significance of the issues presented by this case, *amici curiae* respectfully submit this motion seeking leave to file the accompanying brief.

May 3, 2001

Respectfully submitted,



Paula Brantner
(Counsel for *Amicus Curiae*)

National Employment Lawyers
Association (NELA)
600 Harrison Street, #535
San Francisco, CA 94107

Counsel for *Amicus Curiae*
NELA

Mary Ellen Signorille
(Counsel of Record)
AARP Foundation Litigation

Melvin Radowitz
AARP

601 E Street NW
Washington, DC 20049
(202) 434-2060
Counsel for *Amicus Curiae*
AARP

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No. 99-1786

IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, et al.,

Petitioners,

v.

JANETTE AND ERIC KNUDSON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION IN SUPPORT OF NEITHER PARTY

INTERESTS OF *AMICI CURIAE*[y]

The interest of *amici* is set forth in the accompanying motion for leave to file this brief

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[y] No counsel for any party authored any portion of this brief. No party other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

Mertens v. Hewitt Associates, 508 U.S. 248 (1993), should be overruled. Not only is the jurisprudence in determining the parameters of the term "appropriate equitable relief" inconsistent between circuits, but, more importantly, the underlying analyses are also in conflict. What these decisions illustrate is that the analysis set forth in *Mertens* is neither workable nor analytically sound. The difference between make-whole relief, which *Mertens* held was not equitable relief, and restitution and other traditional equitable relief, which *Mertens* endorsed, is not a bright-line test. In fact, those circuit courts which have granted relief are doing what courts of equity did -- award make-whole relief. Quite simply, make-whole relief should be the meaning of "appropriate equitable relief." *Id.* at 266.

Moreover, *Mertens*' view of ERISA is seemingly at odds with the view of ERISA espoused in more recent Supreme Court precedent. *Mertens* minimized ERISA's grounding in trust law while last term's decision in *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250-51 (2000), embraced it. *Mertens'* view of ERISA is also in tension with the view endorsed in *Varity Corp. v. Howe*, 516 U.S. 489 (1996). In *Varity*, the Court found that Congress determined that ERISA was to provide more protection than trust law, not less. *Id.* at 497. Contrary to the *Varity* Court's finding of congressional intent, *Mertens* interprets ERISA to provide less protection to participants.

Finally, should this Court decide not to overrule *Mertens*, but instead to decide this case more narrowly on the parameters of equitable relief, it is imperative that this Court send a message to the circuit courts that "what is good for the goose is good for the gander." The Court's rationale should apply not just to reimbursement cases, but also to other requests for restitutionary relief.

ARGUMENT

I. *MERTENS v. HEWITT ASSOCIATES* SHOULD BE OVERRULED BECAUSE ITS INTERPRETATION OF "APPROPRIATE EQUITABLE RELIEF" HAS BEEN HONORED IN THE BREACH.

Mertens v. Hewitt Associates, *supra*, is the seminal case interpreting the term "appropriate equitable relief" under ERISA § 502(a)(3). The precise question before the Court was "whether a nonfiduciary who knowingly participates in the breach of fiduciary duty imposed by [ERISA] is liable for losses that an employee benefit plan suffers as a result of the breach." *Id.* at 249. In *Mertens*, the Court's analysis focused on the remedies available, specifically what relief the phrase "appropriate equitable relief" embraced. *Id.* at 255. The Court concluded that "appropriate equitable relief" under § 502(a)(3) did not encompass compensatory or money damages because "[m]oney damages are, of course, the classic form of legal relief." *Id.* Instead, the Court expressly stated that equitable relief for a nonfiduciary's knowing participation in a fiduciary breach referred to "categories of relief that were typically available in equity such as injunction, mandamus, and restitution, but not compensatory damages." *Id.* at 256.

A. The Circuit Courts Have Struggled to Reconcile *Mertens* With the Award of Traditional Equitable Remedies.

Although *Mertens* held that "appropriate equitable relief" under § 502(a)(3) did not include compensatory or money damages, the Court provided little guidance concerning the scope of the term "appropriate equitable relief," and in particular, what constitutes restitutionary relief. The circuit courts have struggled to give some meaning to the term "appropriate equitable relief." Most circuit courts realized that an extremely narrow reading of the *Mertens* decision would leave plaintiffs with no or limited remedies, and thus gut any

protections provided by § 502(a)(3).[4] *Id.* at 274. And so, many of the circuit courts have taken various steps to prevent this result, and thus to attempt to reconcile *Mertens* with the purposes of courts of equity.

In order to award a remedy where equity would seem to call for one, some circuit courts have simply recharacterized plaintiff's request for relief so that it meets the *Mertens* standard of traditional equitable relief. *See, e.g., Health Cost Controls of Illinois v. Washington*, 187 F.3d at 710 (recharacterizing suit for restitution, which may be either legal or equitable, as one for constructive trust on money in escrow account). Other courts have drawn distinctions between the fiduciary and nonfiduciary status of the defendant, holding that suit against a fiduciary, unlike a nonfiduciary, permits make-whole relief since courts of equity awarded such relief. *See Strom v. Goldman, Sachs & Co., supra*; *Health Cost Controls of Illinois v. Washington, supra*; *but see McLeod v. Oregon Lithoprint, Inc., supra* (monetary damages are not available, regardless of the defendant's fiduciary or nonfiduciary status). In circuits permitting subrogation claims against participants, they have awarded an offset of the attorneys' fees paid by the participant, acknowledging that in equity the court would have allowed such an offset because the recovering party, that is the plan, would not have collected this money without the efforts of the plaintiff, that is the participant. *See*

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[4] *See generally* E. Lopez, *Equitable Remedies for Breach of Fiduciary Duty Under ERISA After Varity Corp. v. Howe*, 18 BERKELEY J. EMPLOYMENT & LAB. L. 323 (1997); R. Rouco, *Available Remedies Under ERISA Section 502(a)*, 45 ALA. L. R. 631 (Winter 1994) (arguing that narrow interpretations of 502(a) have undermined ERISA's primary goals); E. Darroch, *Mertens v. Hewitt Associates: The Supreme Court's Dismantling of Civil Enforcement Under ERISA*, 1994 DET. C.L. REV. 1089 (Fall 1994).

Wal-Mart Stores, Inc. v. Wells, 213 F.3d 398, 402 (7th Cir. 2000).[5]

What these cases illustrate is that the distinction in *Mertens* between make-whole relief and traditional equitable relief is not workable in today's world. And, the distinction of where the remedy originated becomes less important given that the purpose of courts of equity was to award make-whole relief, and they had done so for hundreds of years. As the Seventh Circuit sagely intoned: "there is nothing to suggest that ERISA's drafters wanted to embed their work in a time warp. . . . We do not think the motto of our law should be "let the dead bury the living." *Health Cost Controls of Illinois v. Washington*, 187 F.3d at 711.

Significantly, there is still a crucial difference between legal and equitable relief. Unlike legal relief, appropriate equitable relief will never include any compensatory and extra-contractual damages such as punitive damages, awards for emotional or mental distress and loss of reputation. D. Dobbs, LAW OF REMEDIES: DAMAGES-EQUITY-RESTITUTION § 12.5 (2d ed. 1993). *Accord, Mertens v. Hewitt Associates*, 508 U.S. 248, 270-71 (1993) (dissenting opinion); *cf. Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 145-48 (1985) (extra contractual damages are not available under § 409).[6]

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[5] In *Wal-Mart Stores, Inc. v. Wells*, 213 F.3d 398, 400 (7th Cir. 2000), the court questioned whether ERISA permits monetary relief to be awarded as an adjunct to other traditional equitable relief inasmuch as equity permits courts to award monetary relief under the "clean up" doctrine. The court did not need to reach this issue in its decision.

[6] Moreover, courts have discretion to determine what is "appropriate" in awarding equitable relief, depending on the circumstances of the case. *Cf. Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (cause of action was appropriate where plaintiffs could not proceed under any other section of ERISA).

Quite simply, this Court should acknowledge and ratify that the circuit courts are interpreting "appropriate equitable relief" to mean make-whole relief and acting as courts of equity have always done for hundreds of years. *Mertens*, 508 U.S. at 263-64, 266.

B. *Mertens* Is in Tension with the View of ERISA Embraced by Subsequent Supreme Court Precedent.

There is now a tension between the *Mertens* decision and this Court's unanimous decision in *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. at 250-51. *Mertens* rejected the argument that its narrow reading of equitable relief failed to acknowledge ERISA's roots in the common law of trusts. *Mertens*, 508 U.S. at 255-56. The majority refused to interpret "appropriate equitable relief" as whatever relief a court of equity was empowered to provide to remedy actions brought by beneficiaries for a breach of trust. In contrast, in *Harris Trust*, the Court held that the potential recission of the transaction, restitution of the purchase price, and disgorgement of profits fell within the remedies provided under the common law of trusts concerning a fiduciary's transfer of trust property to a third person. *Harris Trust*, 530 U.S. at 250. Thus, *Mertens* seemingly minimized ERISA's grounding in trust law while *Harris Trust* embraced it.[7]

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[7] This tension cannot be rationalized on the basis that the *Mertens* plaintiff was an individual participant while the *Harris Trust* plaintiff was a fiduciary. This should be a distinction without a difference because, of course, fiduciaries must represent the interests of the participants and beneficiaries. *See generally Washington-Baltimore Newspaper Guild v. Washington Star Co.*, 543 F. Supp. 906 (D.D.C. 1982) (in the context of attorney-client privilege, trustees of employee benefit plans are fiduciaries who owe undivided duty of loyalty to benefit plan participants); *In re Gulf Pension Litigation*, 764 F. Supp. 1149 (S.D. Tex. 1991) (attorneys for a plan trustee were required to turn over documents to plaintiff participant because attorneys' clients were plan's participants and beneficiaries, not plan fiduciary); ERISA § 404(a), 29 U.S.C. § 1104(a).

Indeed, *Mertens*' view of ERISA's purposes and scope is also at odds with the view of the Supreme Court in *Varity Corp. v. Howe*, 516 U.S. at 497. In *Varity*, the Court emphasized that trust law does not control completely under ERISA, but instead acts only as a guide as to the minimum protections ERISA provides. The Court recognized that Congress had determined "that the common law of trusts did not offer completely satisfactory protections." *Id.* Based on *Varity*, ERISA should be interpreted to provide greater protections to participants and beneficiaries than the law of trusts provided.

Thus, *Mertens* should be overruled as being inconsistent with *Harris Trust* and *Varity*.

II. THE NINTH CIRCUIT'S INTERPRETATION OF *MERTENS* AS PRECLUDING MONETARY RELIEF IN MOST CASES UNDER ERISA § 502(A)(3) IS JUST PLAIN WRONG.

Of all the circuits, the Ninth Circuit has taken the most restrictive view of what constitutes "appropriate equitable relief" under the standard articulated in *Mertens*. Indeed, the Ninth Circuit has been adamant that *Mertens* generally bans monetary relief, regardless of plaintiff's characterization of the relief.

Amici believes that the Ninth Circuit's reading of *Mertens* is too narrow. There is no doubt that "appropriate equitable relief" under § 502(a)(3) includes restitution.[8] *Mertens v. Hewitt Associates*, 508 U.S. at 260. And, there is no doubt that restitution may include monetary relief. *Harris Trust*, 530 U.S. at 250-51 (request for monetary relief in the form of restitution

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[8] It is of no matter whether restitution is accomplished through the imposition of a constructive trust, disgorgement, an accounting, subrogation, or an equitable lien. *See generally* RESTATEMENT OF RESTITUTION (Second) §§ 1, 160 &161; D. Dobbs, LAW OF REMEDIES § 4.1(1) at 225, 240 (2d ed. 1993). The result is still the same.

is "appropriate equitable relief"). Indeed, more often than not, restitution is monetary relief that acts as a substitute for the specific item gained by the defendant. D. Dobbs, LAW OF REMEDIES § 4.1(1) at 259 (2d ed. 1993).

Moreover, contrary to the implication of the Ninth Circuit's line of cases, restitution does not require wrongdoing. *See* D. Dobbs, LAW OF REMEDIES at 224; RESTATEMENT OF RESTITUTION (Second) § Part 1, Chapter 7. Significantly, the Ninth Circuit has only recognized restitutionary relief as appropriate equitable relief where the defendant has been unjustly enriched or there is proof of fraud or other wrongdoing, and plan assets have been taken. *Compare Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998), *cert. denied*, 120 S. Ct. 170 (1999), *with Waller v. Blue Cross*, 32 F.3d 1337 (9th Cir. 1994) (imposition of constructive trust upon employers' ill-gotten profits from their breach of fiduciary duties); *Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock*, 861 F.2d 1406 (9th Cir. 1988).

An excellent example of the Ninth Circuit's faulty reasoning is *Bast v. Prudential Ins. Co., supra*. In *Bast*, the Ninth Circuit was faced with an allegation of a breach of fiduciary duty for failure to timely provide the decedent with the benefits to which she was entitled. The court concluded that to grant restitution in the amount that the plan saved by not providing the benefits was equivalent to money damages. *Id.* at 1010. The court also rejected the argument that an appropriate equitable remedy would be a constructive trust in the amount that the plan saved by not providing the benefits because although "Prudential Insurance Company] may have been unjustly enriched, it did not take money from the plan." *Id.* at 1011. *Compare with Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487 (D.C. Cir. 1998) (restitution of erroneously paid benefits is appropriate equitable relief where party has been unjustly enriched). The principles of unjust enrichment do not require the actual taking of plan assets; instead it is the reasonable expectations of the parties that should govern. *See generally id.* at 495; RESTATEMENT OF RESTITUTION (Second) § 1.

Moreover, the Ninth Circuit has not recognized that the principle of unjust enrichment, without more, does not always adequately address attempts to readjust the economic situations between the parties, and that equitable principles permit the courts to fashion other types of remedies. D. Dobbs, LAW OF REMEDIES at 227. Indeed, equitable remedies are appropriate when legal remedies are inadequate. *Id.* at 257. And, restitution is always equitable when it is sought as remedy for a breach of fiduciary duty. RESTATEMENT OF TRUSTS (Second) § 197 ("the remedies of the beneficiary against the trustee are exclusively equitable").

If this Court should decide that the Ninth Circuit's reading of equitable relief is too narrow in this case, and decides that it will not overrule *Mertens*, then it is imperative that the Court send a message to the Ninth Circuit and other courts that the rationale in this case applies generally to all types of cases where equitable relief is sought, not just in subrogation or contractual reimbursement cases. Otherwise the jurisprudence in this area of the law will remain as muddled as it has been.

CONCLUSION

For the foregoing reasons, AARP and NELA urge the Court to overrule *Mertens*, or alternatively, hold that restitution includes monetary relief in instances other than where "ill-gotten" assets or profits are taken from a plan through fraud, wrongdoing, duress, or other unconscionable behavior, and

reverse the decision of the Ninth Circuit, and remand for findings consistent with the Court's decision.

May 3, 2001

Respectfully submitted,

Paula Brantner
National Employment Lawyers Association (NELA)
600 Harrison Street, #535
San Francisco, CA 94107
(415) 227-4655

Counsel for *Amicus Curiae* NELA

Mary Ellen Signorille
(Counsel of Record)
AARP Foundation Litigation

Melvin Radowitz
AARP

601 E Street NW
Washington, DC 20049
(202) 434-2060

Counsel for *Amicus Curiae* AARP

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GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF MARYLAND HMO SUBROGATION PLAINTIFFS FOR LEAVE TO FILE AN *AMICI CURIAE* BRIEF AND BRIEF IN SUPPORT OF RESPONDENTS

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

F. Paul Bland, Jr.
(Counsel of Record)
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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Victor Riemer, Stephen and Janet Marx, Douglas Harvey, Shade Popoola, Sabriyaha Singh, Angie Dixon, and Phyllis Balthrop (collectively the "Maryland HMO Subrogation Plaintiffs") respectfully move this Court, pursuant to Rule 37.4, for leave to file a brief as *amici curiae* in support of respondents Janette and Eric Knudson. Consent to file this brief was granted by respondents but withheld by petitioners.

The Maryland HMO Subrogation Plaintiffs are each plaintiffs in cases filed in Maryland state courts alleging that HMOs illegally recovered funds from them under claims of

subrogation.[1] Their argument that HMOs were prohibited from engaging in subrogation under Maryland law was accepted in full by Maryland's highest court in *Riemer v. Columbia Medical Plan*, 747 A.2d 677 (2000).[2] The Maryland HMO Subrogation Plaintiffs

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[1] Mr. Harvey is the plaintiff in the case of *Harvey v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Ct. Mont. Cty. Civil No. 211349); Mr. Riemer and the Marxes are the named plaintiffs in the putative class action *Riemer v. Columbia Medical Plan* (Cir. Ct. How. Cty. Civil No. 96 (A31528) and 4th Cir. No. 98-1136; Ms. Popoola is the named plaintiff in the putative class action *Popoola v. M.D. Individual Practice Ass'n* (Cir. Ct. Mty. Cty. Civil No. 21148); Ms. Dixon is the named plaintiff in the putative class action *Dixon v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Ct. Mty. Cty. Civil No. 211350v); Ms. Singh is the named plaintiff in the putative class action *Singh v. Prudential Health Care Plan, Inc.* (Cir. Ct. Mty. Cty. Civ. No. 211346v); and Ms. Balthrop is the named plaintiff in the putative class action *Balthrop v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Cty. Mty. Cty. Civil No. 211347). Some of these cases have been removed to federal court and are the subject of motions to remand, or of appeals relating to ERISA preemption.

[2] Shortly after *Riemer* was decided, the Maryland legislature passed legislation permitting HMOs to subrogate, though under the new bill (with one exception) they may only do so to the extent of their actual costs (rather than the claimed fair market value of their services), and they may only do so if they directly adjust their premiums downwards. *See* 2000 Maryland Laws, Chapter 569. While this statute is retroactive for a period of 24½ years, the question of whether the retroactivity provision violates the Maryland and United States Constitutions is before Maryland's highest court in *Harvey v. Kaiser Foundation Health* (continued...)

have a strong interest in seeing that this body of state law is not swept aside.

This case poses the question of whether an ERISA plan may bring an action under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce a subrogation claim. The Maryland HMO Subrogation Plaintiffs have no interest in (and will not address) most of the statutory arguments related to this question, such as whether a cause of action for restitution is legal or equitable in nature, or whether such a cause of action is comparable to one for the imposition of a constructive trust. Nonetheless, the Maryland HMO Subrogation Plaintiffs have a significant interest in this case because petitioners and several of their *amici* have urged this Court to hold that subrogation is required to prevent the unjust enrichment of insureds.

In making this request, petitioners and some of their *amici* go beyond the question of the proper meaning of Section 1132(a)(3) and ask this Court to hold that ERISA embodies substantive law favoring or even requiring that health insurers be permitted to pursue their insureds for subrogation. If this Court were to embrace this suggestion, it would create a significant new body of federal law in an area long governed by state law, and potentially override the state law relied upon by the Maryland HMO Subrogation Plaintiffs. Such an expansion of federal law would eradicate the substantive judgments of myriad states about the wisdom of permitting subrogation.

While respondents oppose petitioners' arguments on the proper interpretation of Section 1132(a)(3), their case does not involve a state anti-subrogation statute. Respondents, therefore,

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[2] (...continued)
Plan of the Mid-Atlantic States, Inc., No. 121 (Md. September 2000 Term).

have little reason to address the effect that the arguments advanced by petitioners and their *amici* could have on such statutes or on ERISA's relationship to similar substantive state law provisions. The Maryland HMO Subrogation Plaintiffs seek leave to file the enclosed brief to ensure that the Court appreciates the serious flaws in petitioners' and their *amici's* attacks on subrogation and the dangerous extent to which those attacks threaten this Court's past interpretation of ERISA, established state laws, and important principles of federalism.

Respectfully submitted,

F. Paul Bland, Jr. *(Counsel of Record)*
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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No. 99-1786

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JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICI CURIAE* MARYLAND SUBROGATION PLAINTIFFS

INTEREST OF MARYLAND HMO SUBROGATION PLAINTIFFS[1]

The Maryland Subrogation Plaintiffs are plaintiffs in cases filed in Maryland state court seeking to recoup funds taken from them by Health Maintenance Organizations ("HMOs") under claims of

[1] No counsel for any party authored the brief in whole or in part, and no person or entity other than *amici curiae* made any monetary contribution to its preparation or submission.

subrogation. Maryland's highest court has already held that the HMOs actions violated a Maryland state anti-subrogation law. *Riemer v. Columbia Medical Plan*, 747 A.2d 677 (2000). The petitioners and some of their *amici* here, however, are urging this Court to go beyond the question presented in this case – which does not involve a state anti-subrogation statute – and issue a ruling calling the validity of such statutes into question. We submit this brief both to explain why the Court should reject that suggestion and to expose the dangerous flaws in the attacks on subrogation advanced by petitioners and their *amici*.

SUMMARY OF ARGUMENT

This case poses the question of whether an action under 29 U.S.C. § 1132(a)(3) to enforce a subrogation claim is a legal or equitable action. To resolve this question, petitioners and some of their *amici* have asked this Court to wade into the underlying merits of this controversy and to announce that subrogation by insurers is necessary to avoid the unjust enrichment of insureds. Such a substantive judgment is not necessary to the resolution of this case, and contradicts the substantive judgments of a number of states.

A number of state legislatures and high courts have adopted legislation or common law rules that prohibit medical insurers from pursuing their own insureds for subrogation (or sharply limit the practice). Other state legislatures and high courts have permitted health insurers to engage in subrogation. Thus, notwithstanding the one-sided policy pronouncements in the briefs of petitioners and their *amici*, this is a subject on which state lawmakers and courts can and do reasonably disagree, and there are powerful policy arguments in favor of the proposition that health insurers should be barred from engaging in subrogation.

If this Court were to announce a new rule of substantive law that subrogation is necessary to avoid unjust enrichment, it would raise the possibility that ERISA's enforcement provisions (including Section 1132(a)(3)), would conflict with ERISA's Savings Clause (29 U.S.C. § 1144(b)(2)(A)). For some time, it has been recognized that ERISA does not prevent states from prohibiting (or allowing or otherwise regulating) subrogation by insurers. Indeed, this Court has held that state anti-subrogation statutes are clearly a "regulation of insurance" within the scope of ERISA's Savings Clause, except with respect to self-funded plans, which are themselves excepted from ERISA's Savings Clause. *FMC v. Holliday*, 498 U.S. 52 (1990). As this brief will set forth below, if this Court were to declare that subrogation is necessary to avoid unjust enrichment, the health insurance industry has already signaled its intention to use such a statement to mount an ERISA preemption attack upon state anti-subrogation statutes notwithstanding ERISA's Savings Clause.

The assertion by petitioners and their *amici* that health insurers should be permitted to engage in subrogation because subrogation is good policy is contrary to the considered judgment of many state legislatures and state high courts. It is also wrong. The views of these state authorities are supported by powerful policy arguments and should not be swept aside. Subrogation gives health insurers a windfall by providing them with a second recovery for medical costs for which they have already been paid a premium. Subrogation by health insurers is thus contrary to the long-standing doctrine of the collateral source rule, which has been adopted by the vast majority of states and has been endorsed by this Court since 1854. Subrogation by health insurers also typically denies personal injury claimants a full recovery for their injuries, and has not been shown to have any impact whatsoever on health insurance premiums. Accordingly, this Court should reject the suggestion by petitioners and their *amici* that it go

beyond the issue presented in this case and call into question the validity of state laws banning subrogation.

ARGUMENT

I. CONTRARY TO THE SUGGESTIONS OF PETITIONERS AND THEIR *AMICI*, ERISA DOES NOT REQUIRE THE ENFORCEMENT OF SUBROGATION CLAUSES.

A. PETITIONERS AND THEIR *AMICI* URGE THIS COURT TO ATTACK THE SUBSTANTIVE JUDGMENT UNDERLYING STATE ANTI-SUBROGATION STATUTES.

Many states have statutes or common law rules prohibiting or sharply limiting subrogation by some or all health insurers.[2]

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[2] While the majority of states permit health insurers to pursue their members for subrogation when those members recover monies from third parties, "[a] small but solid minority of jurisdictions have rejected the insurance industry's attempt to expand subrogation beyond claims for property damage." Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 Dickinson L. Rev. 581, 584-85 (1992) (hereafter "Baron, *Subrogation on Medical Expense Claims*"). States prohibiting or sharply limiting subrogation by health insurers include Arizona, *Allstate Ins. Co. v. Druke*, 576 P.2d 489 (Ariz. 1978); Missouri, *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418 (Mo. Ct. App. 1965); Nevada, *Maxwell v. Allstate Ins Co.*, 728 P.2d 812 (Nev. 1986); North Carolina, *Hampton Indus. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); Pennsylvania, 75 Pa. Cons. Stat. § 1720; Oklahoma, *Aetna Cas. and Sur. Co. v. State Board for Property and Cas. Rates*, 637 P.2d 1251 (Okla. 1981); and Virginia, Va. (continued...)

Although petitioners and their *amici* never mention these laws, their arguments threaten to have a huge impact upon them. These parties have asked this Court to hold that subrogation by health insurers is an "equitable" cause of action within the meaning of § 1132(a)(3) because it is necessary to prevent the "unjust enrichment" of insureds who receive tort recoveries from third parties. *E.g.*, Brief for the Petitioners at 34, 36; Brief for the United States as *Amicus Curiae* Supporting Petitioners at 10, 14, 27; *Amici Curiae* Brief for the National Association of Subrogation Professionals, Inc. in Support of Petitioners at 2-3, Brief of *Amicus Curiae* American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America ("The Health Insurance Industry Brief") at 3.

If this Court were to so hold, it is certain that health insurers will use this holding to attack anti-subrogation laws. Health plans have repeatedly raised the argument, for example, that actions implicating ERISA's enforcement provisions are preempted even if they fall within ERISA's Savings Clause. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) (declining to resolve insurer's argument that ERISA's Enforcement Clause overrides ERISA's Savings Clause and preempts a state law within the Savings Clause). While the Maryland HMO Subrogation Plaintiffs sharply disagree with this argument, if the Court construes Section 1132(a)(3) as creating a substantive rule of law in support of subrogation, that new rule will be used by health plans to cast a cloud over the many state laws limiting or

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[2] (...continued)
Code Ann. § 38.2-3405. A great many other states limit subrogation by providing that health insurers may not recover sums for subrogation from their insureds unless and until the insureds have been "made whole" by the third party tortfeasor.

prohibiting subrogation, and will thus potentially undermine the scope and force of ERISA's Savings Clause. Creating such a new substantive rule would thus jeopardize a number of state laws, and be directly contrary to this Court's direction that courts should be reluctant to find that ERISA preempts traditional bodies of state law.[3] Apparently unhappy with the laws of many states that limit or prohibit subrogation, the insurance industry is urging this Court to use this case as an opportunity to enunciate a new body of federal law that, the industry hopes, would sweep aside these state laws.

B. STATE ANTI-SUBROGATION STATUTES ARE SAVED FROM ERISA PREEMPTION BY ERISA'S SAVINGS CLAUSE.

While the scope of ERISA preemption under Section 1144(a) is quite broad, "[t]he saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(4), phrased with similar breadth, exempts from preemption 'any law of any state which regulates insurance.'" *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 360 (1999). "The effect of the [savings] clause is to save state laws governing the business of insurance from preemption that would otherwise occur by application of [the preemption clause]." *Stuart Circle Hosp. Corp. v. Prudential Health Mgt.*, 995 F.2d 500, 502 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993). This Court has explained that the Savings Clause "substantially qualifie[s]" ERISA's Preemption Clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985). Just two years ago, this Court again held that a body of state law falling within ERISA's

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[3] *See Pegram v. Hertrich*, 120 S. Ct. 2143, 2158 (2000) ("in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.")

Savings Clause is not preempted by ERISA. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999).[4]

This Court has made clear that, with respect to insured health plans, state anti-subrogation statutes fall within ERISA's broad

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[4] A wide variety of important state statutes and regulations have been spared from ERISA preemption under the Savings Clause, including state statutes mandating that insurance policies contain certain minimum benefits, *Metropolitan Life*, 471 U.S. 724; statutes prohibiting unreasonable discrimination in preferred provider organizations, *Stuart Circle*, 995 F.2d at 500; statutes requiring that substantially similar policies be issued by successor insurers, *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 300 (6th Cir. 1991); bad faith tort claims that are limited to the insurance industry, *Hill v. Blue Cross Blue Shield of Alabama*, 117 F. Supp. 2d 1209 (N.D. Ala. 2000); acts requiring that restricted pharmacy networks allow other pharmacies the right to provide drug benefits to insureds, *American Drug Stores, Inc. v. Harvard Pilgrim Health Care*, 973 F. Supp. 60 (D. Mass. 1997); laws forcing insurance companies to reimburse attorneys that procure workers compensation, *Levine, Benjamin, Tushman, Bratt, Jervis and Stein v. Paul Revere Life Ins. Co.*, 875 F. Supp. 404 (E.D. Mich. 1995); acts requiring the continuation of coverage for disability insurance policies, *Miller v. Northwestern National Life Ins. Co.*, 915 F.2d 1391, 1393 (9th Cir. 1990); laws providing for continued coverage by HMOs for a divorced spouse, *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996); notice-prejudice rules, *Dang v. UNUM Life Ins. Co. of America*, 175 F.3d 1186, 1192 (10th Cir. 1999); and torts for breach of an implied covenant of good faith and fair dealing, *Lewis v. Prudential U.S. Healthcare, Inc.*, 1999 U.S. Dist. LEXIS 18942 (N.D. Okla. October 20, 1999).

Savings Clause.[5] In *FMC*, 498 U.S. 52, this Court found that there was "no dispute" that a Pennsylvania anti-subrogation statute was within ERISA's Savings Clause. 498 U.S. at 60-61. *FMC* held that the anti-subrogation statute "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain." *Id.* at 61 (citing *Metropolitan Life*, 471 U.S. at 740-41). This Court held that the anti-subrogation act did "not merely have an impact on the insurance industry; it [was] aimed at it." 498 U.S. at 61 (citation omitted.) This Court thus concluded that "[t]his returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the Savings Clause by virtue of the Deemer Clause, therefore, it is not preempted." 498 U.S. at 61.[6]

Other courts have followed this Court's direction that anti-subrogation acts are within the Savings Clause as they apply

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[5] ERISA's Deemer Clause, 29 U.S.C. § 6, 1144(b)(2)(B), represents an exception to the Savings Clause. As this Court stated in *UNUM*, self-funded health insurance plans are preempted from the Savings Clause. 526 U.S. at 367 n.2. Nonetheless, state laws that are protected from preemption with respect to insured plans are preempted with respect to self-funded plans.

[6] This Court nonetheless held that the Pennsylvania statute was preempted in *FMC* because, even though it fell within the Savings Clause, the defendant in *FMC* was self- funded. In this case, petitioners' plan is self-funded and, therefore, not within the scope of ERISA's Savings Clause. Nonetheless, as set forth above, if this Court were to embrace the suggestion of petitioners and their *amici* that it create a new federal rule of law endorsing subrogation by HMOs, the health insurance industry would surely attempt to use this new federal intrusion into the traditionally state law field of subrogation to launch an ERISA preemption attack upon those state laws limiting the industry's practices.

to insured plans. *See Medical Mutual of Ohio v. DeSoto*, 234 F.3d 298, 308 (6th Cir. 2000); *Hampton Indus. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); *United Food & Comm. Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986) ; *Whitlinger v. Continental Cas. Co.*, 2001 WL 85836 at *6 (E.D. Va. Jan 22, 2001); *Donlan v. Greater Cleveland Reg'l Transit Auth.* 2000 U.S. Dist. LEXIS 6735 (N.D. Ohio, Mar. 31, 2000); *Blue Cross and Blue Shield of Alabama v. Fondren*, 966 F. Supp. 1093, 1097 (M.D. Ala. 1997); and *Blue Cross and Blue Shield of Alabama v. Lewis*, 754 F. Supp. 849 (N.D. Ala. 1991).

C. STATE REGULATIONS OF SUBROGATION ARE ENTIRELY CONSISTENT WITH ERISA'S SCHEME.

Some of petitioners' *amici* claim that ERISA's statutory structure and underlying purposes mandate that health insurers be permitted to collect subrogation. *E.g.* Health Insurance Industry Brief at 15-23. Those arguments are simply wrong. State anti-subrogation laws are entirely consistent with ERISA's scheme. ERISA principally operates to enforce the terms of benefit plans – to make sure that plan providers actually provide the benefits that are promised in the plan, whatever they may be. ERISA does not regulate the substantive terms of benefit plans, and it does not instruct benefit plans that they must include or not include any particular substantive terms. Accordingly, ERISA completely preempts state laws that mandate that employee benefit plans be administered in a particular way, laws that bind plan administrators to particular choices, or laws that provide alternate mechanisms for enforcing ERISA benefits. *See Coyne & Delaney Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996). *See also Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146 (W.D. Wis. 1991), *aff'd*, 993 F.2d 1293 (6th Cir.), *cert. denied*, 510 U.S. 916 (1993) ("Rather than regulating the substance of benefits plans, ERISA regulates the administration, disclosure and reporting of

benefit plans to ensure that employees receive the benefits promised to them in writing.") Because state anti-subrogation statutes are regulations of the substantive provisions of insurance contracts, and not procedural regulations, they are entirely consistent with ERISA's scheme of preemption.

This Court should also embrace the well-established line of cases holding that ERISA embodies no substantive rule with respect to subrogation. *See Member Servs. Life Ins. Co. v. American Nat'l Bank and Trust Co. of Sapulpa*, 130 F.3d 950, 958 (10th Cir. 1997) ("ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content.") (quoting *Ryan v. Federal Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)). This neutrality is in keeping with Congress's respect (reflected in ERISA's Savings Clause) for diverse state regulations of the business of insurance.

The Health Insurance Brief also asserts that a federal rule requiring subrogation by health insurers is necessary to fulfill Congress' intent that ERISA "assure uniformity and efficiency in plan administration." As this Court has recognized in the subrogation context, however, ERISA was designed to leave this issue to the states with respect to insured plans:

> By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

FMC Corp., 498 U.S. at 63.

II. AS MANY STATES HAVE RECOGNIZED, THERE ARE STRONG POLICY ARGUMENTS AGAINST PERMITTING HEALTH INSURERS TO SUBROGATE.

As noted above, petitioners and their *amici* urge this Court to reach the substantive conclusion that subrogation by health insurers is required to prevent the unjust enrichment of injured insurers. Petitioners and their *amici* thus ask this Court to express an adverse judgment as to the longstanding anti-subrogation laws of various states without even mentioning the existence of these laws.

In fact, the unjust enrichment argument put forward by petitioners and their *amici* gets the situation exactly backwards. As many commentators and state high courts have noted, subrogation by health insurers provides the *insurers* with a windfall – a second payment for medical care for which the insurers have already been paid (through premiums). As the leading scholar in this area has written:

> The successful collection of a subrogated claim results in a "windfall" to the insurer in the following sense: In paying the loss, the insurer simply pays an anticipated loss on a risk that has been actuarially distributed over a pool of similarly-situated insureds. The initial setting of the insurance premium for the transfer of the risk from the insured to the insurer encompasses the insured's pro-rata share of total estimated losses for the pool, as well as the insured's pro-rata share of the insurer's profit to be realized from the insurance undertaking. The prospect of a successful subrogation collection is not a factor in the insurer's rate determination. In fact, the conjectural and remote nature of subrogation militates against including it as a factor in premium rate setting. Thus, when an insurer pays out on an

> insured risk, any recovery that the insurer is able to obtain through subsequent subrogation is a "windfall" to the insurer.

Baron, *Subrogation on Medical Expense Claims*: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws, 96 Dickinson L. Rev. 581, 582 (1992) (footnotes omitted). The Nevada Supreme Court has expanded upon this point:

> [W]e conclude that it violates public policy to allow an insurer to collect a premium for certain coverage and then allow the insurer to subrogate its interest and deny the insured his benefits. Precluding the subrogation of the insurer does not result in a double recovery for the insured because the insured is merely receiving the benefits for which he has already paid. . . . Allowing subrogation deprives the insured of the coverage for which he had paid and results in a windfall recovery for the insurer.

Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986).

Petitioners and some of their *amici* attempt to avoid the windfall problem by arguing that, if insurers are not successful in pursuing their insureds for subrogation, this will result in the *insureds* receiving a windfall because they would recover money for expenses for which they had not paid. This assertion ignores the fact that plaintiffs *have* paid for this care when they paid their premiums. As Maryland's high court has held, "one of the purposes of" anti-subrogation statutes "is consumer protection." *Riemer v. Columbia Medical Plan*, 747 A.2d 677, 689 (Md. 2000). Noting that "[t]he entire [Maryland HMO Act] statutory scheme emphasizes that an HMO, by its definitions, provides health care services on a *prepaid* basis," *Id.* at 688 (emphasis in original) the court explained that insureds should not be required to pay subrogation because they have "already paid for services

rendered" through their premiums. 747 A.2d at 690. "The allegation that the insured will make a double recovery in the absence of medical payments subrogation is not persuasive for the insured has paid for that additional coverage." *Allstate Insurance Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981). "Subrogation on non-property damage claims renders insurance coverage 'illusory' because the insured receives nothing for the separate premium paid to the insurer when a tort-feasor is liable for damages." Baron, *Subrogation on Medical Expense* Claims, at 588 (footnote omitted).

The claim of petitioners and their *amici* that subrogation by health insurers is necessary to prevent unjust enrichment of insureds stems from a premise – that insureds may not both recover funds from third parties and receive funds from insurers – that is flatly contrary to the longstanding doctrine of the collateral source rule. "The collateral source rule, widely recognized throughout the United States, generally provides that recoveries by a plaintiff from sources other than the defendant tortfeasor are not to be considered in determining the liability of the defendant or the amount of damages." Calvin R. Wright, *The Collateral Source Rule in Georgia: A New Method of Equal Protection Analysis Brings A Return to the Old Common Law Rule*, 8 Ga. St. U. L. Rev. 835, 835 (1992). This Court has firmly embraced this doctrine since 1854:

> The defense set up in the answer, that the libelants have received satisfaction from the insurers, cannot avail the respondent. The contract with the insurer is in the nature of a wager between third parties, with which the trespasser has no concern. The insurer does not stand in the relation of a joint trespasser, so that satisfaction accepted from him shall be a release of others. This is a doctrine well received at common law. . . .

The Propeller Monticello v. Mollison, 58 U.S. 152, 155 (1854). This doctrine is also widely accepted in nearly all of the states, despite the many and repeated efforts of the insurance industry to have it eliminated. In *Plank v. Summers,* 203 Md. 552 (1953), for example, Maryland's high court held "that where hospital and medical services are furnished gratuitously to the injured party, he can recover the value of those services from the tort-feasor." 203 Md. at 562. In support of this conclusion, the court noted:

> Here also it might well be considered that medical and hospital services supplied by the Government to these members of the United States Navy were part of the compensation to them for services rendered, and therefore that by their service in the Navy they had paid for these. If, by their services, the appellants paid for the medical and hospital expenses, certainly the value of these are proper items for the jury to consider in arriving at the amount of damages to be paid by the appellee.

Id. In the *Riemer* case, Maryland's high court recognized that the anti-subrogation provisions of Maryland's HMO Act were consistent with that state's jurisprudence recognizing the collateral source rule. 747 A.2d at 690.

The collateral source rule is so well established in the states that on a number of occasions state high courts have struck down as unconstitutional legislation that attempted to override the rule. *See, e.g., O'Bryan v. Hedgespeth*, 892 S.W.2d 571 (Ky. 1995); *Carson v. Mauer*, 424 A.2d 825 (N.H. 1980); *Denton v. Con-Way Southern Express, Inc.*, 402 S.E.2d 269 (Ga. 1991); *Farley v. Engleken*, 740 P.2d 1058 (Kan. 1987). The collateral source rule is thus directly analogous to state anti-subrogation laws. In each instance, the insured has "paid" for their medical care by paying their premiums to the insurer, just as the *Plank* plaintiffs had "paid" for their medical care by working for the Navy.

The Health Insurance Industry Brief paternalistically asserts that the health insurers are taking subrogation monies from their insureds for the insureds own good, and that injured insureds greatly benefit from having their money taken from them this way. Health Insurance Brief at 6. These self-serving pronouncements are based on the patently false premise that wherever insureds make more money, their insureds will benefit equally. In fact, subrogation in the health insurance context is affirmatively harmful to insureds. Because it is impossible to quantify the true loss to the plaintiff from a personal injury, subrogation in that setting will often leave the plaintiff without full compensation:

> Subrogation rights are commonly allowed when the insured sustains a *fixed* financial loss. . . . In personal insurance contracts, however, the exact loss is never totally capable of ascertainment, and therefore the same reasons militating against double recovery do not obtain.

Aetna Cas. and Sum. Co. v. State Bd. for Property and Cas. Rates, 637 P.2d 1251, 1255 (Okl. 1981) (emphasis in original; footnote omitted). *See also Allstate Ins. Co. v. Druke,* 576 P.2d 489, 492 (Ariz. 1978):

> The rule against assignability of personal injury claims is based in sound public policy. A victim's medical expense insurance coverage does not provide full indemnity. While it may indemnify him completely for his medical expenses . . . , such expenses may constitute only a portion of his total loss. In addition to other "out-of-pocket" losses, . . . an accident victim often suffers non-economic losses such as physical pain and mental anguish which are often not monetarily indemnifiable and never insurable. Under the repayment provision in the instant case, the insurance company obtains full reimbursement for its medical expense

payments regardless of whether the victim's tort recovery fully covers his actual damages.

See also Reitler, 628 P.2d at 670 ("the injured person often must compromise the personal injury claim, either because of liability problems or because of limited coverage carried by the tort-feasor. Yet under subrogation the plaintiff's insurer makes a full recovery."); *Maxwell*, 728 P.2d at 815 (same); Baron, *Subrogation on Medical Expense Claims*, at 589.

The Health Insurance Industry Brief also claims that permitting subrogation will reduce health insurance premiums. Brief at 11-12, 16-17. There is no empirical support for this proposition, however. The health insurance industry, which alone has possession of the tapestry of multi-state premiums, makes no effort to argue (much less prove) in its brief that health insurance premiums in the numerous states that forbid subrogation are higher than premiums in the states that permit subrogation. Is there any serious claim that health insurance premiums are far higher in Virginia than in the District of Columbia, for example? The Health Insurance Industry Brief relies upon the patent fiction that each additional dollar of revenue goes not to higher profits or to higher executive compensation, but instead to reduced premiums.

In fact, a number of state legislators and judges have found that claim to be false. The Arizona Supreme Court, for example, has stated:

> In terms of public policy, the only justification for allowing an insurance company to recoup the benefits it contracted to pay out in exchange for the receipt of premium payments which are presumably actuarially adequate would be the lowering of premium rates as a result of such recoupment. This is generally not the case:

> "Subrogation is a windfall to the insurer. It plays no part in the rate schedules (or only a minor one), and no reduction is made in insuring interests . . . where the subrogation right will obviously be worth something."

Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (citations omitted). *See also Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965) ("'[C]onditioning' medical payments coverage [upon subrogation] does not, in fact, work a perceptible reduction in the premium charged for such coverage.")

The Health Insurance Industry Brief correctly states that doctrine of subrogation generally has a long history in the law, Brief at 7, but incorrectly suggests that subrogation by *health insurers* in personal injury cases has an equally long history. In fact, subrogation by health insurers is a practice of relatively recent origin, and the historic body of law permitting subrogation stems from property damage cases, and not from personal injury cases. "The doctrine of subrogation has its genesis in *property* insurance, an area of the law of subrogation that has remained fairly stable." Baron, *Subrogation on Medical Expense Claims*, at 583 (emphasis in original). *See also* Keith E. Edeus, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. Ill. U. Rev. 509, 512 (1997) ("Under the common law, the doctrine was held not to allow subrogation of personal injury claims, so most jurisdictions initially refused to so extend the doctrine.") It was not until the 1960's that insurers began to seek subrogation in health insurance cases. *Id.* To strike down state anti-subrogation laws would be a sweeping act, and the Health Insurance Industry's suggestion that all its members have been subrogating everywhere for a long time is simply not accurate.

CONCLUSION

This case involves the correct interpretation of 29 U.S.C. § 1132(a)(3). Petitioners and their *amici* have, however, asked this Court to go beyond the question presented and declare that federal law under ERISA contradicts (and, they hope, therefore overrides) a host of state laws restricting subrogation by health insurers.

This Court should reject that request. Nothing in ERISA or any other federal law requires subrogation by health insurers, or provides that such subrogation is necessary to avoid the unjust enrichment of the injured insureds. The question of who is unjustly enriched when health plans do or do not subrogate is one on which many states disagree, and nothing in federal law imposes an answer one way or the other. The ability of states to restrict or prohibit subrogation by health insurers is protected by ERISA's Savings Clause, and very strong policy arguments support those states who choose to enact such laws. There is no justification for this Court to override these state laws, and this Court should reject the covert suggestions of petitioners and their *amici* that it should do so.

Respectfully submitted,

F. Paul Bland, Jr. (*Counsel of Record)*
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE CO., EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,
Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF *AMICUS CURIAE* IN SUPPORT OF THE JUDGMENT BELOW BY INVITATION OF THE COURT

RICHARD G. TARANTO
Counsel of Record
FARR & TARANTO
1220 19th Street, NW
Washington, DC 20036
(202) 775-0184

June 29, 2001

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QUESTION PRESENTED

Whether petitioners' suit for money allegedly due under an ERISA plan reimbursement provision is an action for "appropriate equitable relief" under Section 502(a)(3) of ERISA.

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IN THE

Supreme Court of the United States

No. 99-1786

GREAT-WEST LIFE & ANNUITY INSURANCE CO., EARTH SYSTEMS, INC., AND THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,
Petitioners,

v.

JANETTE KNUDSON AND ERIC KNUDSON,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* IN SUPPORT OF THE JUDGMENT BELOW BY INVITATION OF THE COURT

Pursuant to this Court's order dated March 19, 2001, this brief is submitted in support of the judgment of the Ninth Circuit in this case.

STATEMENT

In this case, as in many others, a beneficiary of an employer-sponsored medical plan, covered by the Employee Retirement Income Security Act of 1974 (ERISA), was injured in an accident, and the ERISA Plan paid for her medical expenses. The beneficiary filed and pressed a state-court tort action against alleged tortfeasors to recover damages, including for many items, such as future medical expenses and lost earnings (from what here was a life-altering injury), not paid for by the Plan. Neither the ERISA Plan nor

its representatives assisted or participated in the state-court action, even after receiving notice of a settlement proceeding in which liens on the recovery would be paid. Instead, alleged fiduciaries of the ERISA Plan initiated a second action, in federal court, under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), invoking a reimbursement provision of the ERISA plan to demand payment from the injured beneficiary of the amount the Plan had expended for her medical care.

The district court in this case, agreeing with the injured beneficiary, held that the particular plan provision at issue allowed reimbursement only out of the third party's settlement payments made for past medical expenses, not out of the payments made for (a small portion) of other (amply documented) losses. The court of appeals did not decide the proper interpretation and application of the plan reimbursement provision at issue. It held instead that this action for money was not within ERISA § 502(a)(3)'s authorization for a fiduciary to sue for "appropriate equitable relief."

A. Petitioners and the Plan

In 1981, petitioner Earth Systems, Inc., an employer, established an employee benefit plan to provide medical benefits for its employees and their dependents, subject to ERISA and California law. JA 189-90, 204. Earth Systems established a formal Trust to carry out the plan, and trustee Jerol Brown identified the Trust as the legal entity constituting the Plan, a petitioner here. JA 177, 187. The "only plan documents" were the 1981 Trust Agreement and a Summary Plan Description. JA 207.

The Trust Agreement obliges Earth Systems to pay to the Trust the amounts needed for the Trust to pay claims (JA 190), while also allowing the Trust to purchase insurance directly for the beneficiaries (JA 198). The Agreement states that Earth Systems' board of directors had "appointed a

Board of Trustees (the 'Trustees') to administer the Plan" (JA 189) and that "[t]he Trustees . . . shall be the Plan Administrator as defined in Section 3(16)(A) of ERISA [29 U.S.C. § 1102(16)(A)] and the fiduciary with the rights, powers, duties, responsibilities, discretion and immunities set forth in the Plan" (JA 192). The trustees had "the authority to direct the investment, management and control of Trust assets" (JA 192), to appoint agents as needed to carry out their duties (JA 193), and to exercise a broad range of general powers to operate the Trust (JA 195-200).

The second relevant plan document is the Summary Plan Description (the "Booklet"), which is excerpted at JA 54-66. The Booklet identifies Earth Systems, Inc. as the "Policyholder/Employer," names "Denise Shelton, Human Resources Manager, Earth Systems, Inc." as the "Plan Administrator," and defines the terms of the benefits plan at the relevant time. JA 61-62. Immediately after a provision for "co-ordination of benefits"—"to correct overcoverage which occurs when a person has health coverage for the same expenses under two or more" plans providing benefits (JA 54)—the Booklet sets forth a "Provision for Right of Recovery," which is the basis for the present lawsuit. JA 58-59.

The provision first states that "[a] third party may be liable or legally responsible for expenses incurred by a Covered Person for[] an illness; or a sickness; or a bodily injury." JA 58 (boldface omitted throughout this paragraph). In that case, the Plan will "pay any benefits which are payable for the expenses incurred by the Covered Person for the treatment of such illness, sickness or bodily injury (the Loss)." JA 58. The Plan, however, at its option has

> the right to recover from the Covered Person any payment for benefits paid for treatment of such Loss under this Booklet which the Covered Person is entitled to receive from the third party.

JA 58. The Plan has "a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person receives" from the responsible third party (or its insurer or guarantor or from uninsured motorist insurance). JA 58. That "lien will not exceed: the amount of benefits paid under [the] Booklet for the treatment of the Loss; or the amount received by the Covered Person for such medical treatment from the third party." JA 59. The Covered Person must "cooperate fully" with the Plan, and if a recovery is obtained from a third party and the Plan is not reimbursed "fully for any benefits paid under this provision," then the Covered Person "will be personally liable . . . to the extent of such recovery up to the amount of the first lien." JA 59.[1]

The essential dispute on the merits is over the scope of the reimbursement right under the plan. *See* JA 244. The position urged by respondent Janette Knudson—and adopted by both the state and federal trial courts considering it, but not discussed by the court of appeals—is that this recovery provision (like the coordination of benefits provision) targets only *duplication* of payments to the injured person and thus reaches only money paid by the third party (alleged tortfeasor) for the medical expenses covered by the plan, not money paid by the third party for other losses such as future

[1] The provisions quoted in the paragraph in text use "we" and "us" to describe both the payments made and the recovery rights, and the Summary Plan Description (at V-10) says: "'We', 'our' and 'us' will be used in reference to:—for Health Benefits, the Employer . . . ." Ex. 25 to Def. Cross-Motion for Summary Judgment. Consistent with the limited class of permitted plaintiffs under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) ("participant, beneficiary, or fiduciary"), petitioners, throughout their brief and elsewhere, treat "the Plan" as having made the payments and being entitled to the claimed recovery. *See, e.g.*, Pet. Br. 4, 6, 11, 12, 13, 15, 18, 23, 24, 28, 29, 34, 35; JA 77-78 (Right of Recovery Agreement); JA 85 (complaint); JA 90, 92 (amended complaint); JA 180 (Brown declaration). This brief accordingly refers to the Plan's asserted right to recover.

medical expenses or lost income or loss of enjoyment of life from a long-term disability. The provision begins by introducing its subject in terms of past expenditures, *i.e.*, "*expenses incurred*," for which a third party may be liable but that the Plan pays. It states that the Plan has "the right to recover from the Covered Person any payment *for benefits paid for treatment of such Loss under this Booklet* which the Covered Person is entitled to receive from the third party."[2] It states that the lien "will not exceed . . . the amount received by the Covered Person *for such medical treatment* from the third party," and it restricts the liability of the Covered Person to "the amount of [that] lien." JA 58-59 (emphases added).[3] *See U.S. Healthcare, Inc. v. O'Brien*, 868 F. Supp. 607, 610-11 (S.D.N.Y. 1994). Petitioners, in contrast, have urged that the provision reaches (up to the amount of benefits paid by the Plan) any payments made to the injured person by a third party on account of the injury, whether for Plan-paid medical expenses or otherwise, and without any Plan sharing of the costs of obtaining the settlement.[4]

[2] The possible confusion from the phrase "payment for benefits paid" may be alleviated by re-arranging the sentence: the Plan has "the right to recover from the Covered Person any payment" "which the Covered Person is entitled to receive from the third party" "for benefits paid for treatment of such Loss under this Booklet."

[3] The Right of Recovery Agreement signed by Eric Knudson, on which petitioners rely, introduces its topic as the possibility that a third party "may be liable for like benefits," *i.e.*, the Plan-paid benefits. The sentence in the Agreement about recovery seems to focus on payments for Plan-paid expenses: "the Plan may recover from me any payment for benefits paid under this Plan . . . which I or my dependents may be entitled to receive from a third party" ("for" omitted at ellipsis). JA 77-78.

[4] Chief Judge Posner, speaking for the Seventh Circuit, recently explained, in terms applicable to the present case, some of the consequences of such a demand: it "would allow the plan to free ride on the efforts of the plan participant's attorney"; it would "gratuitously deter the exercise of the tort rights of plan participants" who can easily (as here) "lose part of [their] plan benefits simply by virtue of having exercised

The third petitioner in this case (besides Earth Systems and the Plan) is Great-West Life & Annuity Insurance Company (Great-West), whose relation to the other two petitioners was defined by two agreements, entered into simultaneously in 1990. In a Services Agreement—separately signed by a "Plan Administrator" and Contractholder Earth Systems' Treasurer (JA 31)—Great-West undertook to provide "non-discretionary" benefit-payment services to the Plan (JA 25). The Agreement states that "under no circumstances shall Great-West be designated as plan administrator or a fiduciary of the Plan" and that it does not "confer upon Great-West any authority or control respecting management of the Plan[or] authority or responsibility in connection with administration of the Plan." JA 28; *see* JA 178 ("non-discretionary claims service administrator").

In a separate agreement, Great-West issued to Earth Systems ("the Contractholder") a group contract for stop-loss insurance, under which Great-West, in exchange for premiums, bore the risk that plan benefits would exceed certain designated amounts for which Earth Systems was itself responsible. JA 35-38[5]; *see* Pet. Br. 3

[their] right to bring a tort suit against a third party" (the reimbursement claim, arising only if there *is* a recovery, can be *more* than the net proceeds, leaving the participants worse off than if they never sue); that "prospect might well deter a suit likely to result in a judgment or settlement not much larger than the benefits available under the plan," producing "undercompensation for harms [other than medical expenses] that were unrelated to the type of harm [medical expenses] to which the benefits pertain"; and "[t]he plan itself might well be worse off in the long run, as it would have to incur attorneys' fees in order to enforce its right of subrogation." *Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir.) (Posner, C.J.), *cert. denied*, 121 S. Ct. 441 (2000).

[5] As of January 1, 1994, Earth Systems changed its plan from "self-funded" to insured—an important distinction for ERISA purposes. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). Before then, Earth Systems had responsibility for providing the needed funds for

("stop-loss insurance coverage . . . reimbursed the employer," not the Plan). While the stop-loss contract states that it created no "rights or obligations whatsoever on the part of Great-West with respect to the persons covered under the plan, or their beneficiaries" (JA 42), it provides that Earth Systems "assign[ed] to Great-West all of its rights to make, litigate, negotiate, settle, compromise, release or waive," in the "sole discretion" of Great-West, any claim "under the Right of Recovery Provision contained in the Plan." JA 45. Subsequent adjustments to the stop-loss contract (JA 46-49, 50-53) set forth the priority of distribution of money collected under the recovery provision (first to Great-West, then to Earth Systems), *see* JA 49, 52-53, and state: "The Contractholder hereby assigns to Great-West any and all rights the Contractholder, as Employer, may have under the Right of Recovery Provision contained in the Plan." JA 49, 53.

B. The Accident And Its Aftermath

On June 10, 1992, Janette Knudson and Eric Knudson (then Janette's husband), along with three passengers, were involved in an automobile accident that left Janette a quadriplegic from a severe injury to her spinal cord. JA 112, 145. As a result of her injuries, she incurred substantial medical expenses. At the time, Eric Knudson was an employee of petitioner Earth Systems, and both he and his wife were "Covered Persons" under the Summary Plan Description. The Plan eventually paid $411,157.11 in medical expenses, though petitioners have not alleged or established that any of that money was ever paid to Janette Knudson (or Eric), rather than the providers of her medical care. JA 238.

the Plan, and Earth Systems purchased insurance for itself, with the insurer having no direct relationship to the beneficiaries. Beginning in 1994, the Plan purchased insurance, with the beneficiaries then having a direct relationship, as insureds, to the insurer. JA 177 n.1, 208, 215.

In August 1992, two months after the accident, Great-West wrote a letter to Eric Knudson stating, among other things, that the Plan was entitled "to be a party to any legal action you may take because of an accident or injury" (JA 71) and "to full reimbursement for expenses" paid by the Plan (JA 71). In September 1992, Great-West wrote a letter to Janette Knudson (at the same address as Eric Knudson's) stating that Great-West "on behalf of the Plan has a first lien Right of Recovery to any sums paid in settlement or judgment on your behalf as a result of the accident" and asking for completion of the "Right of Recovery Agreement" (prepared by Great-West and included with the letter, *see* JA 68). JA 75-76. The next month, Eric Knudson signed and returned the agreement, evidently without authorization from Janette Knudson, as she attested (JA 113). The Agreement "request[ed] that benefits be paid by the Plan . . . with the understanding . . . that another party or insurer may be liable *for like benefits* for which they will make payments" (emphasis added) and then addressed subrogation (in one paragraph) and reimbursement (in another) (JA 77-78):

> In consideration for the plan paying benefits and in accordance with the terms of the Plan, I agree that the plan may be subrogated to me or my dependent's rights for any benefits from the other party. I agree to transfer to the Plan any right I or my dependents may have to take legal action against the other party. I also agree to cooperate fully with the Plan in asserting its right to subrogate and supply to the Plan any and all information. I will execute all documents reasonably necessary to carry out its right to recover from the other party any benefits paid under the Plan which are subject to this provision.
>
> I also understand that under the terms of the Plan, the Plan may recover from me any payment for benefits paid under this Plan for which I or my dependents may be

> entitled to receive from a third party. The Plan shall automatically have a first lien upon any recovery, whether by settlement, judgment or otherwise, that I or my dependents receives from another party, the other party's insurer or guarantor, or my own insurer or guarantor. Said first lien shall be for the amount of medical and hospital benefits paid by the Plan, I shall be personally liable to the Plan to the extent of such recovery up to the amount of its first lien. I agree to cooperate fully with the Plan in asserting its rights to recover.

C. The State Court Tort Action

In late 1993, Janette Knudson and Eric Knudson filed a tort suit in the California courts seeking to recover from Hyundai Motor Company, the manufacturer of the car, and others. JA 238. Great-West had notice of the ligitation from the outset (Pet. Br. 6-7), but it did nothing to participate or to assist financially in the litigation. After more than three years of discovery and vigorous disputes over the alleged defects in the automobile and the cause of Janette Knudson's injuries (JA 145-46), Janette Knudson and the defendants in March 1997 negotiated a settlement of the state-court case in the amount of $650,000, conditional on court approval. JA 161-66 (conditional release). (Eric Knudson does not appear on the relevant papers; in April 1997 he informed Great-West that he and Hyundai had settled his loss–of-consortium claim. C.A. Appellee ER at 261. *See* note 9, *infra*.)

Janette Knudson petitioned the state court for an order to approve the settlement and, as part of that settlement, to establish a Special Needs Trust under California Probate Code § 3611 to provide (if only for a limited time) for some of her special needs that will not be covered by state Medicaid ("Medi-Cal") or related programs. JA 145-60; *see* JA 115-38 (Trust). The petition was joined by Louise Curinga, "a long term friend" who had "agreed to be the

Trustee of the Janette Knudson's Special Needs Trust." JA 145. It recited, with supporting declarations, that future medical expenses alone would be more than $2.5 million and lost earnings more than $819,000, that Janette Knudson "will need lifetime care and lifetime attendant assistance," and that she would need special wheelchairs, beds, vehicles, house alterations, and other help. JA 148; *see* JA 142 (noting lost-earnings figure from Knudson's evidence). Pursuant to California Probate Code § 3602, notice was given to California authorities so that they might satisfy their liens (for Medi-Cal payments made) and ensure that the statutory qualifications for the Trust were met. JA 149-53.

The petition laid out the calculation of how much money was to be put into the Special Needs Trust—$256,745.30, representing the $650,000 settlement amount, minus the attorney's fees and other costs of obtaining the settlement (totaling $373,426),[6] minus the amounts to be paid to the two known lienholders, namely, Medi-Cal and Great-West. JA 153-58. A payment of $5,000 was reserved for Medi-Cal. JA 157. As for Great-West, the petition reported the dispute over the proper amount, noted that Great-West had never intervened or filed a lien notice in the state-court suit, and explained why, under the language of the plan, Great-West's claim (defined by the lien created by the Plan) was limited to "'the amount received . . . *for [the Plan-funded] medical treatment* from the third party.'" JA 154-55 (quoting plan) (emphasis added). Accordingly, the proposed Great-West

[6] Although petitioners report the total of $373,426 (Pet. Br. 7), they omit the breakdown: (a) recovery of costs (including expert fees) of $161,760 advanced by counsel over the years of the litigation, and (b) an attorney's fee of $216,666, representing a 1/3 share (reduced from the agreed-on 40% share). JA 157. Janette Knudson attested that, upon review (by herself and Trustee Louise Curinga) of the attorney's fee and costs, she did not object to those charges, considering "the testing, time, effort, and numerous experts employed . . . as consultants in order to attempt to prove the crash worthiness theory." JA 113.

payment was based on the allocation of the settlement amount to various categories of loss traceable to the accident: 45% for future medical expenses; 40% for loss of enjoyment of life, distress, and long-term disability; 5% for lost earnings; 5% for housing, transportation, and other needs; and 5% for past medical expenses. JA 154. With Great-West limited to recoveries for past medical expenses, the 5% figure was applied to the net settlement ($650,000 minus the fees and costs of $373,426, resulting in $276,574) to arrive at a $13,828.70 payment to Great-West. JA 157.[7]

On March 26, 1997, Janette Knudson gave notice of the proposed settlement to Great-West by mailing it the papers seeking state-court approval of the settlement. JA 233. On April 22, 1997, the day before the state-court hearing date, Great-West, calling itself a "defendant" and asserting that the state-court action involved federal claims relating to ERISA benefits, filed notices of removal of the case. JA 167-70; *see* JA 233 (date of filing). On June 30, 1997, the federal district court remanded the case to state court, concluding that Great-West, not being a defendant in the case, could not remove it. JA 171-75; *see* JA 233.

A few days later, a new notice of a new settlement-approval date in state court was sent to and received by Great-West and Earth Systems, Inc., which still did not intervene or otherwise participate in the state-court suit. JA 217, 233-34. In late July 1997, the state court approved the settlement, with $13,828.70 to go to Great-West, $2,729.42 to Medi-Cal (whose actual claim was lower than

[7] If the $411,157.11 sought here by Great-West were subtracted directly from the $650,000 settlement amount, $238,842.89 would remain. If Medi-Cal were then paid its $2,729.42, and the out-of-pocket expert fees and other costs advanced by counsel ($161,760) were paid, $74,353.47 would remain. Out of that amount would have to come (a) a recovery to Janette Knudson and (b) a fee to counsel who worked for years to obtain the settlement.

the reserved $5,000), $260,015.88 to the Special Needs Trust, and the remainder to Janette Knudson's counsel for his costs and fees. JA 139-44. The court found that Janette Knudson qualified for the Special Needs Trust, which would receive an amount "substantially less than the present value of the future medical expenses" (JA 140-141); that there was a substantial risk of Janette Knudson's not prevailing at all in the "disputed, highly complex product liability" action (JA 141); that the allocation of the settlement amount to various categories of loss was fair (given, particularly, the estimated $2.5 million in future medical expenses and $819,000 in lost earnings) (JA 143); that the plan provision invoked by Great-West is limited to the amount recovered for "past medical expenses" (JA 143); and that the attorney's fees and costs—in a case requiring "considerable discovery, vehicle testing, seat belt testing including the employment of eleven (11) expert witnesses"—were proper (JA 143-44). Hyundai was directed to pay the Trust amount directly to the Special Needs Trust and the remainder to a Client Trust Account held by Janette Knudson's attorney. JA 144. Janette Knudson herself received no money.

On August 1, 1997, the order approving the settlement was mailed to Great-West and Earth Systems, Inc. JA 234-35 (stipulation of parties). On August 21, 1997, notice was given to Great-West that a check of $13,828.70 was being sent. JA 235. Petitioners' attorney responded the next day that all funds should segregated pending the outcome of the federal-court case, but Janette Knudson's attorney replied, the same day, that he had already disbursed the money he had received and the money for the Special Needs Trust had been paid directly into that trust by third-party Hyundai. JA 235.

D. This Litigation

On May 19, 1997, before the federal court rejected the effort to remove the state-court case, Great-West (by itself) filed a complaint in federal district court against Janette and

Eric Knudson, asserting that it was "the assignee for collection" of the Plan for reimbursement purposes. JA 82; *see* JA 81-86. Great-West invoked ERISA § 502(a)(3)(B)(ii), 29 U.S.C. § 1132(a)(3)(B)(ii) ("appropriate equitable relief . . . to enforce . . . the terms of the plan"). *See* JA 82, 85. It asked for a declaration of rights and an injunction requiring the Knudsons "to reimburse the Plan in the amount of $411,157.11 out of any proceeds they recovered from third parties." JA 85-86.

In early July 1997, an amended complaint was filed (JA 87-95; *see* JA 5, 234), now with three plaintiffs (petitioners here)—Great-West, again asserting that it was "assignee for collection" of the Plan for purposes of reimbursement; the Plan itself; and Earth Systems, Inc., which stated that it was the Plan Administrator. JA 88-89. The amended complaint, now also reciting the Right of Recovery Agreement signed by Eric Knudson (JA 91-92), again asserted that the Knudsons violated the plan "[b]y not agreeing to reimburse the Plan [out of] the amount recovered" in the state-court tort suit (JA 92) and invoked ERISA § 502(a)(3) to recover (JA 92). Petitioners asked for an injunction requiring reimbursement of $411,157.11 to the Plan (JA 92), a declaratory judgment declaring the Plan's right to reimbursement in that amount (JA 93), a temporary restraining order and preliminary injunction against continuation of the state-court proceedings for approval of the settlement until the federal court determined petitioners' reimbursement rights and against any disposition of funds received in the settlement (JA 93-94), and a permanent injunction against any such disposition (JA 94). While the concluding prayer for relief requested "an injunctive order enjoining Defendants to reimburse the Plan . . . and for any other relief to which it is entitled" (JA 95), no mention was made of any remedies besides a preliminary or permanent injunction, declaratory judgment, and TRO.

The district court denied the application for a TRO to stop state-court completion of the settlemcnt proceedings. JA 96-99. It relied first on the Anti-Injunction Act's broad prohibition against federal courts enjoining state court proceedings (28 U.S.C. § 2283), concluding that none of the exceptions to the broad bar applied to justify "disrupt[ing] the delicate balance of federalism." JA 98. The court also found petitioners unlikely to succeed, noted that (at the time) "their rights of subrogation remain[ed] intact," and observed (relatedly) that "Great-West has filed this Application after failing for three years to intervene in the state court action." JA 99.

After the state court approved the settlement and the money was disbursed (as described above), and after Janette Knudson answered (JA 100-11), this litigation proceeded in discovery. Petitioners filed a motion for summary judgment in December 1997. Petitioners' position, stated by trustee Jerol Brown, was that the Plan's right of recovery provision, and the Right of Recovery Agreement signed by Eric Knudson, entitled the Plan to recover its $411,157 out of the full $650,000, without deduction for the costs of securing the settlement and without regard to whether Janette Knudson was being made whole for her losses. JA 180-82; *see* JA 185-86 (re-affirming interpretation after considering additional language).[8] Janette Knudson filed a motion for

[8] Petitioners, citing their own Ninth Circuit brief, report that Great-West offered (presumably to Janette Knudson, the alleged obligor) to accept only $200,000 if Janette Knudson's counsel would accept $200,000 as well, leaving $250,000 for the Special Needs Trust. Pet. Br. 7. The $200,000 amount for counsel would, after subtracting the more than $161,000 in out-of-pocket expert fees and other costs incurred by counsel, have left a fee of roughly $39,000. Petitioners do not suggest that such a fee would be reasonable or that they ever offered to pay Janette Knudson's counsel for his years of effort, bearing a substantial risk of no payment at all, that resulted in the settlement from which they sought to benefit.

summary judgment in mid-February 1998 contending that petitioners' recovery was limited to the $13,828.70 they had been offered all along. JA 8-15.[9]

In May 1998, the district court granted summary judgment against petitioners. The court wrote a brief opinion (JA 237-49) and adopted an edited version of Janette Knudson's statement of uncontroverted facts and conclusions of law (JA 210-35). *First*, the court concluded that the state court hearing the tort case had jurisdiction to "determine the status of liens on Janette Knudson's recovery" under ERISA § 502(a)(1)(B), which authorizes a beneficiary "to enforce his rights under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B). *See* ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1) (concurrent jurisdiction over § 502(a)(1)(B) claims). JA 242-43; *see also* JA 228 ("failure after notice to subrogate or to enforce their alleged rights" in state court "preclude[s] them from re-litigating the same issues in this case"). *Second*, the court explained that petitioners' right of recovery must be governed only by the plan provision on the right of recovery, not by the Right of Recovery Agreement signed by Eric Knudson—which could not permissibly alter

[9] The petition for certiorari describes the judgments below as only in favor of respondent Janette Knudson, referring throughout to "respondent" and "Knudson" in the singular. Pet. i, 1-9. Eric Knudson did not appear in the court of appeals, was not served by petitioners in the court of appeals (according to the certificates of service attached to their notice of appeal and their briefs), and was not served and has not appeared in this Court. The relevant papers in the district court, including the "stipulation of facts between the parties" (JA 232), were filed only on behalf of Janette Knudson as defendant, not Eric Knudson (*see* JA 100 (answer); JA 210 (statement supporting summary judgment motion)), who seems to have filed only an opposition to the initial application for a temporary restraining order and an opposition to reconsideration of the summary judgment against petitioners (*see* JA 5-21). *See also* JA 139-60 (state-court settlement and accompanying release and court approval only on behalf of Janette Knudson). This brief hereafter refers simply to Janette Knudson as respondent.

the plan document without amendment. JA 245-46. *Third*, the court held that the plan terms are "abundantly clear" in limiting recovery to amounts "received from a third party *for medical treatment*" (JA 246-47 (emphasis added)); the court therefore rejected the interpretation of trustee Jerol Brown (who it said "was vested with the authority to interpret the Plan") as simply "clash[ing] with the terms of the Plan" (JA 246).[10] *See also* JA 228 (citing the Make Whole Rule presuming no reimbursement until injured person made whole, *see Barnes v. Indep. Automobile Dealers Ass'n of Cal. Health & Welf. Benefit Plan*, 64 F.3d 1389 (9th Cir. 1995)). *Finally*, the court held that the amount of the recovery for medical treatment expenses was resolved by the state court (JA 247), while separately declaring that the damages apportionment was fair (JA 228). *See also* JA 229 (adopting conclusion that stop-loss agreement unlawful). Accordingly, the court granted summary judgment against petitioners (and awarded attorney's fees, *see* Pet. App. D1-D6).[11]

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[10] Jerol Brown pointed (JA 185) to the Trust Agreement as vesting him with interpretive authority, but the Trust Agreement nowhere states a discretion to "interpret" or "construe" (JA 189-202), and Brown did not identify the particular language he was relying on. It is unclear, therefore, how the pertinent language fares under the standards for overcoming the presumption of *de novo* review. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Ingram v. Martin Marietta Plan*, 244 F.3d 1109 (9th Cir. 2001); *Feder v. Paul Revere Life Ins. Co.*, 228 F.3d 518 (4th Cir. 2000); *Postma v. Paul Revere Life Ins. Co.*, 223 F.3d 533 (7th Cir. 2000); *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir. 2000) (Posner, J.).

[11] Among the motions the district court denied was petitioners' motion (filed in December 1997, *see* JA 8) to amend the complaint to add as defendants both Janette Knudson's counsel and Louise Curinga, trustee of the Special Needs Trust. *See* JA 249; Pet. Br. 8. Neither on appeal, nor in their petition for certiorari, did petitioners make any argument that, even if summary judgment was proper as to Janette (and Eric) Knudson, it was error to deny leave to amend. *See* JA 252 n.4 (court of appeals noting lack of challenge); C.A. Brief of Appellants 6-7 (statement of issues), 16-31 (availability of § 502(a)(3)), 31-41 (no preclusion by state-court judgment), 41-53 (interpretation of plan terms), 53-58 (enforceability against Janette Knudson of separate agreement signed by Eric Knudson), 58 (remand to determine amount of medical expense recovery), 58-59 (attorney's fees).

E. Court of Appeals Decision

On appeal, the Ninth Circuit affirmed the judgment against petitioners, but on a threshold ground (whether or not deemed jurisdictional). JA 250-53. The Ninth Circuit had held in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997), and reaffirmed in *Cement Masons Health and Welfare Trust Fund for Northern California v. Stone*, 197 F.3d 1003 (9th Cir. 1999), and *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246 (9th Cir. 2000), that "actions by ERISA fiduciaries seeking to enforce an ERISA plan's contractual reimbursement provisions," where the initial benefits (or, for that matter, the recovery from the third-party alleged tortfeasor) were not wrongfully obtained in the first place, do not come within ERISA § 502(a)(3)'s authorization for "equitable relief." *Reynolds Metals*, 202 F.3d at 1248-49; *see FMC Medical*, 122 F.3d at 1262 ("substance of the remedy sought by FMC is money damages for Owens's alleged breach of the Plans"); *Cement Masons*, 197 F.3d at 1007-08. The Ninth Circuit in the present case concluded that those decisions controlled and thus affirmed the judgment against petitioners—for either lack of a cause of action (as *Cement Masons* said) or for lack of jurisdiction (JA 253 n.5).

SUMMARY OF ARGUMENT

The Ninth Circuit's judgment affirming the dismissal of petitioners' suit is correct for two reasons. The suit does not seek "equitable relief" under the standard set by this Court in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). And even if it does, the suit does not seek "appropriate" equitable relief.

To state a cause of action for "equitable relief" under Section 502(a)(3), a claim must, under *Mertens*, seek relief that was traditionally available in equity, for litigants generally, for the type of claim made. A reimbursement claim like petitioners' claim, however, seeks nothing but money due under an obligation to pay. It does not involve specific plan property or its product: the recovery amount claimed is not money that was actually obtained from the plan or the proceeds or profits of such money, let alone money obtained by anyone's wrong or error. Such a money claim was not typically remediable in equity, but had to be pursued at law, even when the substantive basis alleged was unjust enrichment. It is immaterial whether restitution in equity might be available when non-monetary property is involved or when, as in *Harris Trust and Savings Bank v. Salomon Smith Barney Inc.*, 120 S. Ct. 2180 (2000), a claim is for money transferred out of a trust by the trustee's wrongful conduct (though without wrong by the recipient). Nothing shown by petitioners or the United States establishes, that equity typically provided a remedy for a money claim like petitioners', which does not seek return of specific Plan assets (or their profits or proceeds), let alone Plan assets improperly transferred. Indeed, petitioners' claim is deficient for an additional reason: the recovery amount was never received by respondent, making the claim against her one for purely personal monetary liability, and thus outside the equitable restitution remedies of constructive trust and equitable lien.

This conclusion is not overcome by the pleading device of requesting an "injunction" to pay the money claimed. Likewise, blanket invocation of "restitution" (or its "unjust enrichment" basis), which was available in *different* circumstances in the equity and law courts, fails to distinguish whether the *equitable* restitution remedies were traditionally available for the type of claim presented. The law of trusts does not help petitioners either: *Mertens* pointedly rejected a trust-specific application of Section 502(a)(3); and in any

event, a trustee's suit against a beneficiary for money was an action at law if such claims, aside from trust law, were actions at law. Finally, the claim cannot become equitable simply because damages might be unavailable: allowing an injunction to pay money to substitute for damages would simply reverse the congressional rejection of such remedies, as established by *Mertens*' definitive construction of Section 502(a)(3). The potential lack of remedy for plans cannot support a different result: *Mertens* made clear the standard, despite the obvious potential that some wrongs and harms would go unredressed without damages remedies; and, given the breadth of ERISA preemption, leaving wrongs unredressed is far from alien to ERISA. Accordingly, Section 502(a)(3)—which petitioners cannot properly supplement with newly created nonstatutory remedies—does not embrace petitioners' claim.

If this Court nevertheless were to conclude that petitioners' claim seeks "equitable relief," the claim still should be held outside Section 502(a)(3) on the ground that it does not seek "appropriate" relief. The Court's decision in *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996), makes clear that the appropriateness of the relief is an additional requirement for coverage by Section 502(a)(3). A claim should be held not appropriate under the provision if it would harm ERISA interests—*e.g.*, by increasing litigation expenses and interfering with tort suits for recovery—and generate substantial difficulties of coordination and comity between state and federal courts, and if there are alternative avenues for protecting legitimate ERISA interests that avoid those harms. Reimbursement claims like petitioners' are not appropriate for those reasons.

Such reimbursement claims intrinsically generate duplicative litigation, as they add to the (typically) state-court tort suit a new federal proceeding with interrelated issues. The costs and delays of such duplicative litigation must be

borne by beneficiaries and participants and by plans, too, and can impede the completion of the state-court proceedings that produce the very recovery sought by the plans. The plan itself (or its representatives) may even be party to the state-court tort suit under a subrogation provision, which leaves the tort claim to which the plan would be subrogated as a state-law claim in state court. Permitting such fractured and multiple litigation makes no sense, in terms of ERISA interests or the interests of the state and federal judiciaries, where it is not shown to be unavoidable.

Petitioners have not shown that plans cannot protect their interests in enforcing recovery rights through participation in the underlying state-court suit, as by intervening to assert a lien on the recovery amount or to assert rights as subrogee. The sole suggested impediment is that of preemption, but petitioners have not shown that these state-court mechanisms should be preempted. In fact, such mechanisms do not add any obligations to override plan choices about benefits payments or administration, and they do not add any liabilities to those authorized by ERISA: they provide procedural mechanisms for a plan to obtain, under federal-law principles governing application of plan terms, exactly what it claims an entitlement to receive under its own chosen recovery provisions. The sensible course of participation in the underlying state-court case thus has not been shown to be preempted. The duplicative federal-court suits petitioners propose should accordingly be held to be not "appropriate," and thus outside the scope of Section 502(a)(3).

ARGUMENT

I. PETITIONERS' MONEY CLAIM DOES NOT SEEK EQUITABLE RELIEF UNDER SECTION 502(a)(3)

Section 502(a)(3) requires that the relief sought be "equitable relief." Petitioners' suit, however, seeks nothing

more than money to fulfill an obligation to pay. In particular, it does not seek the return of specific property (or even money) once properly conveyed to respondent or the proceeds from any such specific property; indeed, it does not claim money actually ever acquired by respondent. Such a claim traditionally was not typically remediable in equity and is thus outside Section 502(a)(3).

A. Section 502(a)(3) Covers Only Claims Typically Remediable In Equity

In *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), this Court established the meaning of "equitable relief" under ERISA § 502(a)(3). The case involved a claim under Section 502(a)(3) by beneficiaries of an ERISA-covered plan against a nonfiduciary who knowingly participated in a breach of fiduciary duty, causing underfunding of a pension plan that consequently was terminated. 508 U.S. at 250-51. The Court held that the suit was not within Section 502(a)(3) because the beneficiaries sought compensatory damages, not "a remedy traditionally viewed as 'equitable.'" 508 U.S. at 255.

The Court rejected the position that "equitable relief" under Section 502(a)(3) embraced "'whatever relief a court of equity is empowered to provide in the particular case at issue,'" even while acknowledging that "equitable relief" in isolation could bear that meaning. 508 U.S. at 256. Rather, the Court squarely construed "equitable relief" to refer only to "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* (emphasis in original). The Court made clear, moreover, that the standard is not what was ever available from equity courts, not even what was usually or always available under an entire branch of equity jurisprudence (trust law), but what types of relief were "typically" available in equity generally. Over a dissent on this precise point, the Court held that it was not enough that the relief sought was available from equity courts in a whole

category of cases that included the case before it, *i.e.*, suits against trustees or those who knowingly participate with trustees in breaches of trust. *Id.* at 255-56; *id.* at 258 ("'equitable relief" does not mean "'all relief available for breach of trust at common law'").

In its subsequent decisions under Section 502(a)(3), this Court has not altered the *Mertens* standard for "equitable relief." In particular, the Court did not alter the standard in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), which held that beneficiaries could sue under Section 502(a)(3) to obtain individual relief (there, simple reinstatement in a benefits plan), not just relief on behalf of the plan.[12] Nor did the Court alter the *Mertens* standard in *Harris Trust and Savings Bank v. Salomon Smith Barney Inc.*, 120 S. Ct. 2180 (2000), which held that a nonfiduciary who received plan money from a trustee's prohibited transaction could be sued for its return, as restitution, under Section 502(a)(3). As petitioners thus acknowledge, Section 502(a)(3), under the controlling *Mertens* interpretation, is limited to "those remedies traditionally thought of as equitable relief and typically available in equity." Pet. Br. 11; *id.* at 17.

B. A Claim For Money To Fulfill An Obligation To Pay, Not For Return Of Specific Property (Or Its Product), Was Not Typically Remediable In Equity

1. *Petitioners' Claim.*

It is important, at the outset, to recognize that petitioners' claim is not a claim for return of particular money that the Plan paid to respondent and that respondent still retains. First, petitioners have not established that Plan money was

[12] The Court had earlier rejected a claim for individual relief under Section 503(a)(2). *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

ever paid to respondent, rather than to providers of her medical services. *Compare* JA 75 (Great-West letter stating that money "has been paid *to hospital and medical providers on your behalf*") (emphasis added). Second, the money the Plan paid for medical expenses was spent. What petitioners are seeking, therefore, is not *that* money (or profits from its use or proceeds from its exchange); it is new money paid out by a third party, the alleged tortfeasor—money that petitioners might have sought directly had they sued as subrogees. This fact is common to reimbursement claims generally. Third, and more particular to this case, respondent did not in fact ever receive any money in the tort suit: the money went to the Special Needs Trust, to Medi-Cal, and to respondent's counsel (and thereafter to his creditors).

Given those facts, the basis for the claim here is simply the "obligation to pay money to a plan under a reimbursement provision of the plan" (Pet. Br. 12); petitioners seek "to enforce [the plan's] terms" by "compelling the performance of a monetary obligation" (*id.* at 10). *See id.* at 14-15.[13] This obligation is in sum and substance a contract obligation. *Id.* at 10 ("a contractual promise"), 14-15 ("specific performance"); US Br. 18 ("agreement"). Although the United States says that an ERISA Plan, like other trusts, is not "*merely* one type of contract," not "a *garden-variety, arm's-length* contract" (US Br. 16 (emphasis added)), it remains true that "[a]n ERISA plan is a contract." *Herzberger v. Standard Ins.*

[13] Although the United States briefly invokes "double recovery" (US Br. 14), it does not explain what it means. Respondent has always tendered to petitioners the part of the settlement paid for the medical expenses that the Plan had previously paid on her behalf; and given the small recovery compared to the magnitude of respondent's lifetime losses wholly apart from the Plan-paid past medical expenses, the remaining settlement amount in no reasonable sense represents a "double recovery" for Plan-paid medical expenses. Accordingly, if there is "unjust enrichment" here, it is solely because of a plan-defined obligation to pay, not for any other reason.

Co., 205 F.3d 327, 330 (7th Cir. 2000) (Posner, C.J.); *see Tester v. Reliance Standard Life Ins. Co.*, 228 F.3d 372, 375 (4th Cir. 2000); *Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Wells*, 213 F.3d 398, 402 (7th Cir.) (Posner, C.J.) (citing Langbein, *The Contractarian Basis of the Law of Trusts*, 105 Yale L.J. 625 (1995), *cert. denied*, 121 S. Ct. 441 (2000). By the act of accepting the benefits, a beneficiary generally becomes contractually bound to the clear terms on which they were offered. *See* Restatement (Second) of Contracts §§ 56, 59 (1981). It is that obligation which forms the entire basis for the claim to money here.

2. *Reimbursement Claims Generally.*

a. Equity did not generally provide relief for claims for money owed, where plaintiffs were not seeking funds identified as property conveyed in breach of a fiduciary duty (by someone) or its proceeds. Thus, as the United States acknowledges—based on *Raton Waterworks Co. v. Raton*, 174 U.S. 360 (1899), and the Restatement (Second) of Contracts § 359 (no specific performance if "damages would be adequate to protect the expectation interest of the injured party")—specific performance of a contract to pay money was *not* typically available in equity. US Br. 26; *see* Restatement (Second) of Contracts § 373(2) (restitution, even as damages relief, is not available to enforce a contractual obligation to pay a definite sum of money). In other contexts, too, it is well established that claims for money owed traditionally must be pursued at law, not in equity. *See, e.g., United States v. Bank of Metropolis*, 40 U.S. (15 Pet.) 377, 379 (1841); *Gaines v. Miller*, 111 U.S. 395, 397 (1884) (equitable relief denied, explaining: "Whenever one person has in his hands money equitably belonging to another, that other person may recover it by *assumpsit* for money had and received.") (cited in *United States v. California*, 507 U.S. 746, 755 (1993)); *Langenkamp v. Culp*, 498 U.S. 42 (1990) (following *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33,

58-59 (1989); bankruptcy trustee challenging transfer of money made pre-bankruptcy, when the transfer may well have been lawful, must bring a legal action against nonclaimant); *Austin v. Shalala*, 994 F.2d 1170, 1175-77 (5th Cir. 1993) (claims by the United States to recoup mistaken overpayments of benefits are *legal* claims, *i.e.*, claims in quasi-contract traditionally falling "under the common law writ of general assumpsit"); *United States v. Anderson*, 584 F.2d 369 (10th Cir. 1978) (government suits for taxes due are legal, relying on *Damsky v. Zavatt*, 289 F.2d 46 (2d Cir. 1961) (Friendly, J.)).

That traditional limitation did not evaporate when a plaintiff claimed that failure to pay money would result in "unjust enrichment": such claims for money, where not seeking the return of specific property (or its proceeds or profits), were also generally *not* remediable in equity, as the Restatement of Restitution (1937) makes clear. *See Hudson View II Associates v. Gooden* 222 A.D.2d 163, 168, 644 N.Y.S.2d 512, 516 (1st Dept. 1996) (claim for value of services performed and expenditures made for defendant, unlike claim for return of specific property, even when brought under "quasi-contractual theory of quantum meruit," had to be brought as action at law, citing Restatement of Restitution), relied on in *Wal-Mart*, 213 F.3d at 401; Restatement of Restitution, General Scope Note at 1 ("the subject of quasi contracts is limited to actions at law to secure the payment of money"). Thus, after defining restitution as the prevention of unjust enrichment (Restatement § 1, at 12), the Restatement (§ 4, at 17-18) identifies the different legal and equitable remedies available to prevent unjust enrichment in different circumstances and observes that "ordinarily [a] money judgment [against the recipient of the benefit] is obtained by an action at law," though "a decree for money will *sometimes* be rendered by a court of equity," referring to Sections 160-162 (on constructive trusts, equitable liens, and subrogation) for the specifics. § 4, Comment *e* at 21

(emphasis added). Section 160, Comment *a* (at 642), explains that a request for a constructive trust "seeks to recover specific property" whereas a quasi-contract action at law "impos[es] a merely personal liability." Comment *e* (at 645) then explains: "where money is paid by one person to another as a result of a mistake of such a character that the payor is entitled to restitution, he is *ordinarily not entitled to maintain a suit in equity* for the specific recovery of the money, even though the payee still holds the money so that specific restitution would be *possible* . . . ." (emphasis added). Only certain circumstances involving specific money still held by the defendant—if the defendant was insolvent or obtained the money "by an abuse of a fiduciary or confidential relation"—entitled the plaintiff to relief in equity for non-unique money. *Id.*; *see also* Restatement of Restitution § 161, at 650-53 (equitable lien).

The general unavailability of equitable remedies for restitution of *money* reflects the limitation of those remedies to obtaining particular property claimed by (and taken from) the plaintiff, in contrast to establishing personal liability. D. Dobbs, *Remedies* § 4.1 at 223 (1973) ("kinds of claims enforced in equity under the name of constructive trust" involve awards that are "restitutionary or restorative in the sense that the money gained by the defendant is identified with the property taken from the plaintiff" (footnote omitted)); Restatement of Restitution § 160, Comment *e* at 645 ("specific recovery"; "specific restitution"). Thus, Section 215 of the Restatement of Restitution (at 866) points to the "necessity of tracing property" in order to assert the equitable remedies, rather than have "merely a personal claim." *See id.* Comment *a* at 867 ("if it is shown that the property or its proceeds have been dissipated so that no product remains, [plaintiff's] claim is only that of a general creditor"); *see also* Restatement (Second) of Trusts § 202 (vol. 1 at 444) (1959) ("Following Trust Property into Its Product") (where trustee acquires property by wrongful

disposition of trust assets, the acquired property may be subjected to a constructive trust or equitable lien only if it is "the product of the trust property" and "can be traced"); Dobbs (1973), § 4.3 at 242 (stating tracing requirement); *id.* § 5.16 at 423-30 (application to money). Money not specifically traceable to wrongly received funds was generally outside the reach of the constructive trust remedy. *See St. Louis & S.F.R. Co. v. Spiller*, 274 U.S. 304, 310 (1927) (money nowhere segregated is not the traced product within constructive-trust law).

This focus on claims to specific assets (or their product) is reflected in the two references to "restitution" in *Mertens* that are something other than an abstract mention of the term. *See* 508 U.S. at 252 ("'profits of such fiduciary which have been made through use of assets of the plan by the fiduciary'"); *id.* at 260 ("restitution of ill-gotten plan assets or profits").[14] Similarly, the Court's decision in *Harris Trust*, relied on by petitioners (Pet. Br. 10-11, 20, 25-27) and the Government (US Br. 11-12, 29), not only said nothing to alter the *Mertens* standard but involved a claim within the property-specific equitable remedies traditionally available in equity for restitution. It involved an acquisition of trust money that *was* wrongful—because the trustee paid plan money to the defendant in violation of ERISA § 406(a), 29 U.S.C. § 1106(a)—and the suit sought return of just those "ill-gotten trust assets." 120 S. Ct. at 2190. *See* Restatement of Restitution § 160, Comment *e* at 645 (money obtained "by an abuse of a fiduciary or confidential relation").

By contrast, a reimbursement claim on behalf of an ERISA plan does not involve unique currency or money obtained as a

[14] The reference to "constructive trust" in the legislative history has the same focus. Sen. Rep. 93-383 at 105 (1973) ("a constructive trust may be imposed on the plan assets, if needed to protect participants and beneficiaries").

result of a breach of duty by a plan fiduciary or someone acting in concert with a plan fiduciary. A plan beneficiary "is not a fiduciary." *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 704, 710 (7th Cir. 1999). And the money sought (*i.e.*, money coming from a third party) is not money obtained from the plan, or profits from it, or proceeds from exchanging it, let alone money obtained by anyone's breach of duty. The claim is not to specific property within the limited class of traditional equitable remedies for restitution.

This conclusion is not overcome by the argument that equitable remedies might allow for recovery of *some* property when there was nothing improper (on anyone's part) about the initial transfer of the assets to the defendant. Pet. Br. 25; *id.* at 25-28. Neither petitioners nor the United States have shown, contrary to the Restatement of Restitution, that such remedies were typically available when *money* was sought in such circumstances.[15] By the same token, it simply sidesteps the question to argue, as the United States does (US Br. 11, 27-29) that the *defendant* need not have engaged in wrongdoing to be subject to equitable remedies for

[15] Even some of the general relied-on statements about "property" seem to involve erroneous transfers. Thus, the statement at 5 A. Scott & W. Fratcher, *Law of Trusts* § 462.2 (4th ed. 1989), quoted at Pet. Br. 26, is cited by the United States for situations "where the assets were transferred by mistake" (US Br. 28); indeed, the next sentence says, "Thus a constructive trust arises where the title to property is acquired through a mistake, or where property is transferred by a trustee or other fiduciary, in violation of his duty as fiduciary, to a person who has no notice of the violation of duty but who pays no value." 5 Scott Treatise § 462.2 at 314-17. Another treatise quoted by the Government (at 27)—G. Bogert & G. Bogert, *Law of Trusts and Trustees* § 471 (rev. 2d ed. 1978), which in fact stresses the need for "specific property as the res of the trust" (*id.* at 9)—states that the following sections lay out "the principal types of wrongful retention of property which have moved chancery to decree the constructive trust" (*id.* at 29), but neither the United States nor petitioners have identified the present situation among those types.

restitution, even where money was at issue, a point established in *Harris Trust* and not in dispute. What has not been shown is the typical availability of equitable remedies to claim money when the claimed money had not been transferred from the plaintiff (or was the proceeds or profits of such money), let alone transferred by a wrong of *someone*, such as the transferor.[16] Indeed, in what the United States treats as supplying the most pertinent analogy, the Restatement (Second) of Trusts § 283 by its terms states that trust property, if transferred without breach of fiduciary duty, becomes the recipient's "free of the trust."

b. That petitioners' money claim fails under the *Mertens* standard is further supported by the (several) opinions in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), and *Department of the Army v. Blue Fox, Inc.*, 525 U.S. 255 (1999). *See* Pet. Br. 11, 19-20 (discussing *Bowen*); US Br. 19-20 (discussing *Bowen* and *Blue Fox*). *Bowen* allowed a suit under 5 U.S.C. § 702 to reverse an administrative determination denying money claimed by a State under the Medicaid statutes.[17] As *Blue Fox* explained, however, *Bowen*

[16] The United States notes that *Harris Trust* involved an unlawful transfer. US Br. 29 ("property transferred to [the defendant] in breach of a trustee's fiduciary duty"). The quotation in *Harris* of a 19th Century case and treatise by its terms refers generically to "property" and how it was "obtained," "'acquired.'" *See* Pet. Br. 27. Petitioners themselves characterize *Counihan v. United States*, 194 F.3d 357, 361-62 (2d Cir. 1999), as stating a principle for situations where "the *transfer* was in violation of the trust's terms" (Pet. Br. 26 (emphasis added)), and the case was one involving proceeds of an asset that had wrongfully (by arson) been transferred out of the claimant's possession. The Government (US Br. 29) relies on a statement in the Restatment of Restitution § 160 Comment *d*, at 643, that addresses "the result" of imposing a constructive trust, not the standards for imposing one.

[17] The Court stressed that the Medicaid statute was "a complex scheme . . . that governs a set of intricate, ongoing relationships between the States and the Federal Government," in contrast to "statutes that provide compensation for specific instances of past injuries or labors" (487 U.S. at

"did not turn on distinctions between 'equitable' actions and other actions," but, rather, on "what Congress meant by 'other than money damages'" in 5 U.S.C. § 702. 525 U.S. at 261; *see id.* at 262 (*Bowen* did not hinge on distinction "between equitable and nonequitable categories of remedies"). As a result, the majority in *Bowen* did not have to rule, and did not rule, that monetary relief was typically or traditionally available in equity. Supporting its reading of 5 U.S.C. § 702, the Court noted only that such relief "'occasionally'" was available in equity as something other than monetary damages (the classic form of legal relief). 487 U.S. at 895 (quoted at Pet. Br. 19); *see* US Br. 19-20 (*Bowen* and *Blue Fox* recognize that "*some* actions for monetary relief" are suits for equitable relief) (emphasis added).

The majority in *Bowen* thus did not disagree with the analysis in Justice Scalia's dissent (joined by the Chief Justice and Justice Kennedy) unmistakably showing that claims to monetary relief, by whatever form, were typically *not* equitable. Justice Scalia explained that the Court of Claims, though unable to give "equitable relief" (as the majority acknowledged, 487 U.S. at 905), has long heard claims against the United States for money past due (*id.* at 914, 919-21). He explained that it was only "rare suits for a sum of money" that could be brought in equity, those involving not payment for "a past loss" but orders "to prevent future losses" in certain cases. *Id.* at 918. He further explained that invoking "restitution" did not provide for relief

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900 n.31; *see id.* at 905), and, perhaps critically, that the Medicaid statute "directs the Secretary to pay money to the State, *not as compensation for a past wrong*, but to subsidize future state expenditures," again distinguishing laws that "compensate a particular class of persons for past injuries or losses" (*id.* at 905 n.42 (emphasis added); *see id.* at 883-84 (payments "actually a series of huge quarterly advance payments that are based on the State's estimate of its anticipated future expenditures" (footnote omitted)). *See Brighton Village Associates v. United States*, 52 F.3d 1056, 1059 n.3 (Fed. Cir. 1995).

in equity, for "'restitution' in the judicial context *commonly* consists of money damages," as indicated by the fact that the Court of Claims, broadly lacking equitable power, hears such claims. *Id.* at 917 n.2 (emphasis added). And he explained that merely using the form of "injunction" did not allow a suit in equity: "Almost invariably, . . . suits seeking (*whether by judgment, injunction, or declaration*) to compel the defendant to pay a sum of money [other than specific currency or coins] to the plaintiff are suits for 'money damages,' as that phrase has traditionally been applied" to distinguish general legal relief from general equitable relief. *Id.* at 918-19 (emphasis added; footnote omitted); *see id.* at 915-16 (quoted below). This analysis—not disputed by the *Bowen* majority, but found insufficient to answer the *different* question presented under 5 U.S.C. § 702—confirms that monetary claims like petitioners' were not typically and traditionally remediable in equity, as required by the *Mertens* standard.

Blue Fox lends further support to this conclusion. The Court there held, in agreement with the United States, that the determination whether a claim is for "substitute" or "specific" relief, the standard under 5 U.S.C. § 702, is (as Justice Scalia explained with respect to "restitution" and "injunction" in *Bowen*) not controlled by the form of relief claimed. 525 U.S. at 262-63. Thus, although the plaintiff sought an equitable lien, the Court looked through the label placed on the remedy to the substance of the claim itself, explaining that such an equitable lien is merely a device "to satisfy a money claim, usually a claim for unjust enrichment," and therefore "constitutes a claim for 'money damages.'" *Id.* (internal quotation marks omitted).

3. *This Case.*

Even if (contrary to the foregoing) some plan claims for reimbursement out of recoveries obtained by beneficiaries would be within the available "equitable relief" for restitution, petitioners' claim would not be. The constructive

trust and equitable lien remedies require that the property in which the plaintiff seeks a property interest (in whole or in part) be property to which the defendant can, if relief is granted, transfer title (or in which she can convey a partial ownership interest through a lien). Restatement of Restitution § 160, at 640 (defendant must be "person holding title to property"); *id.* Comment *j* at 649 ("Where a person does not acquire title to property but merely obtains possession of the subject matter, he is not chargeable as constructive trustee."); *id.* § 161 (equitable lien fastens on "property of" the defendant); 5 A. Scott & W. Fratcher, *Law of Trusts* § 462, at 304 (4th ed. 1989).[18] Respondent, however, did not receive any of the money paid out in the tort suit. Petitioners bypassed the state-court proceeding that distributed the money, and their complaints do not seek a "constructive trust" or an "equitable lien" (the Plan already has an express lien, *see* Pet. Br. 24 n.10; US Br. 25) for identified property of respondent.

C. The Arguments Presented To Support Section 502(a)(3) Coverage Are Flawed

1. *Injunction*.

Petitioners' primary argument is that it is sufficient that they have requested an injunction ("specific performance," Pet. Br. 20; US Br. 15) in order to make their claim one for "equitable relief" under Section § 502(a)(3). Pet. Br. 12-15.[19] *Mertens*, of course, mentions injunctions ("injunction, mandamus, and restitution") as a common form of equitable

[18] The United States notes that constructive trust and equitable lien are similar remedies, "the difference being that the equitable lien provides a security interest in, rather than complete title to, the property to which it attaches." US Br. 24-25 (citing authorities).

[19] Neither in this Court nor in the court of appeals have petitioners relied on the declaratory judgment request in the amended complaint. Pet. Br. 13-14. Nor does the United States.

relief. But the form of relief cannot possibly control. If merely seeking an "injunction" were enough to come within Section 502(a)(3), then the plaintiffs in *Mertens* could have re-framed their demand as one for an injunction requiring the respondent there to pay the money claimed, thus emptying of all meaning the important limitation on the reach of Section 502(a)(3) adopted by the Court. *See Bowen*, 487 U.S. at 919 (Scalia, J., dissenting) (quoted above); *id.* at 915-16 ("the line between damages and specific relief must surely be drawn on the basis of the substance of the claim, and not its mere form"; "[i]t does not take much lawyerly inventiveness to convert a claim for payment of a past due sum (damages) into a prayer for an injunction against refusing to pay the sum"); *Wal-Mart*, 213 F.3d at 401 (Posner, C.J.) ("[A] plaintiff cannot convert a claim of damages for breach of contract into an equitable claim by the facile trick of asking that the defendant be enjoined from refusing to honor its obligation to pay the plaintiff what the plaintiff is owed under the contract and appending to that request a request for payment of the amount owed. A claim for money due and owing under a contract is 'quintessentially an action at law.'"). What must be critical is whether an injunction was typically available for the kind of claim asserted, as it was not for petitioners' money claim.

2. *Restitution*.

The United States makes a general argument that any action seeking money due under a reimbursement provision is equitable "because it seeks to prevent unjust enrichment." US Br. 14; *id.* at 14-19. This argument suffers from a flaw similar to that infecting petitioners' "injunction" argument. There is no more reason to think that *Mertens* used "restitution" to authorize all restitution, regardless of whether it was typically available in equity for a type of claim, than that it used "injunction" (parallel in the phrase "injunction, mandamus, and restitution") to bring any request for an

injunction under Section 502(a)(3), even one that simply re-pleads a damages claim to request an order for a monetary payment.

The Government's argument incorrectly assumes that all actions alleging unjust enrichment, and for that reason demanding restitution, are equitable. The law is clearly to the contrary. As Chief Judge Posner noted in one of the decisions on which petitioners rely, *Health Cost Controls v. Washington*, 187 F.3d at 710 (relied on at Pet. Br. 24), it is simply "not true" that "restitution is an equitable remedy"; "[t]here really isn't any question about" the fact that "restitution is a legal remedy when sought in a case at law and an equitable remedy when sought in a case in equity." *See also Reich v. Continental Cas. Co.*, 33 F.3d 754, 755-56 (7th Cir. 1994) (Posner, C.J.), cited in US Br. 22 n.15; 1 D. Dobbs, *Remedies* § 4.1(3), at 564 (2d ed. 1993); *Bowen*, 487 U.S. at 917 n.2 (Scalia, J., dissenting) ("'restitution' in the judicial context commonly consists of money damages"). The broad allegation of "restitution," based on "unjust enrichment," is accordingly no help whatever in deciding whether a particular case is legal or equitable.

The fact is that *all* claims for restitution, whether legal or equitable, rest on the notion of restoring the status quo by removing the defendant's gain to correct "unjust enrichment." This concept was the common thread by which the Restatement of Restitution attempted to create a unified field out of its two major subheadings: quasi-contract, a legal action (originally assumpsit); and constructive trust, an equitable remedy. *See* Restatement of Restitution, General Scope Note at 1; Dobbs (1973), § 4.2 at 234-35; *id.* § 4.3 at 241-48; Dobbs (1993), § 4.1(1) at 552 ("unifying thread" of restitution is "to prevent the defendant's unjust enrichment by recapturing the gains the defendant secured in a transaction"); Laycock, *The Scope and Significance of Restitution*, 67 Tex. L. Rev. 1277 (1989). As a result, reliance on "restitution," or

"unjust enrichment" (its basis), cannot demonstrate that this case is within the limited class of restitution claims remediable in equity. What must be critical is whether the particular kind of claim for restitution was one "typically" remediable in equity, as petitioners' claim was not.[20]

3. *Trust Law.*

The United States, recognizing that equitable relief was *not* typically available to enforce an obligation to pay money under a contract (US Br. 26), attempts to escape the force of the general unavailability of the monetary relief sought here by focusing on the special part of equity that governed trusts (genuine trusts, rather than constructive trusts). US Br. 15-19.[21] The Government properly does not assert that respondent is an actual trustee with fiduciary responsibilities. Instead, the Government says that respondent is a beneficiary of a trust and that this suit is analogous to two permissible

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[20] Petitioners rely (Pet. Br. 21-23) on *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F.3d 1347, 1352-54 (11th Cir. 1998), and *Administrative Committee v. Gauf*, 188 F.3d 767, 770-71 (7th Cir. 1999). But *Sanders* declined to rule whether Section 502(a)(3) actually applied, concluding only that it "plausibly" applied (thus supporting federal jurisdiction), and neither *Sanders* nor *Gauf* examined whether, though restitution and injunction remedies *sometimes* are available in equity, such remedies were typically available for money claims of the sort at issue here. The Seventh Circuit subsequently questioned *Gauf* and *Sanders* for just this reason. *See Wal-Mart*, 213 F.3d at 401 (questioning apparent view of *Gauf*, and of *Sanders*, that "all claims of reimbursement by an ERISA plan [are] equitable").

[21] *See Healy v. Commissioner*, 345 U.S. 278, 282-83 (1953) ("A constructive trust is a fiction imposed as an equitable device for achieving justice. It lacks the attributes of a true trust, and is not based on any intention of the parties.") (footnote omitted); Restatement of Restitution § 160, Comment *a* at 641 (a constructive trust "is in fact something quite different from an express trust"; they "are not divisions of the same fundamental concept," but "distinct concepts"); 5 Scott Treatise § 461 at 301; *id.* § 462.1 at 310-13.

equitable actions against beneficiaries: (i) "to enforce an agreement by a beneficiary to pay money into a trust" (US Br. 18, citing 3A A. Scott & W. Fratcher, *Law of Trusts* § 252 at 366 (4th ed. 1988); Restatement (Second) of Trusts § 252 at 635-36); and (ii) "for repayment of an advance made by the trust" (US Br. 18, citing Restatement (Second) of Trusts § 255 at 640-42; 3A Scott Treatise §§ 251, 252 at 363, 366).[22]

There are two fundamental flaws with this argument. First, the argument that the special equity-court powers applicable to trusts define the reach of Section 502(a)(3) is just what the Court rejected in *Mertens*, which held, instead, that Congress was referring in that provision to the remedies *generally* available from equity courts for claims of a particular type. Second, and in any event, the United States has not established that a trustee could bring *in equity* either of the two types of claims against a beneficiary urged as analogous.

The cited Sections 252 and 255 of the Restatement (Second) of Trusts (which are specific examples of a general principle stated in Section 251), as well as the cited sections from the Scott treatise, are by their terms about the right of a trustee to *charge the beneficiary's interest in the trust* in order to capture money owed the trust—which is simply not at issue here. They do not even address the mechanisms by which the trustee may press a separate claim against the beneficiary. Indeed, the commentary to Section 251 makes clear that this special self-help, setoff-type remedy (the trustee deducts the amounts from the beneficiary's interest in the trust) is different from the usual remedies the trustee may pursue against persons generally who should be liable in

[22] The United States notes also that equity entertained suits "against a beneficiary for instigating a breach of trust and to restore payments improperly made to the beneficiary from the trust." US Br. 18. Because the preconditions of that standard (breach of trust, improper payment from the trust) are absent in cases like the present, the United States does not invoke that analogy here. *Id.*

some way to the trust, cross-referencing Section 280 particularly. § 251, Comment *a* (vol. 1 at 633). Strikingly, Section 280 (vol. 2 at 38-42) *denies* that all suits become equitable just because the trustee is pursuing a trust claim: it provides that claims retain their usual legal or equitable status, without regard to the fact that it is a trustee bringing them. The Restatement, in short, defeats the attempt to rely on the trust character of the claimant as sufficient to make otherwise-legal claims against beneficiaries equitable.

This Court, in fact, has recognized in a related context that suits by a trustee for set-off are very different from suits by a trustee for money owed generally. The Court has thus held that a bankruptcy trustee may bring an equitable claim when it seeks money from a creditor who has submitted a claim against the estate but must bring a legal claim when it seeks money from a creditor who has not. *Langenkamp*, 498 U.S. at 44-45; *Granfinanciera*, 492 U.S. at 58-59; *see id.* at 43 ("'Whether a trustee's suit should be at law or in equity is to be judged by the same standards that are applied to any other owner of property that is wrongfully withheld.'"), quoting *Buzard v. Houston*, 119 U.S. 347, 352-53 (1886). So, too, here: that a trustee might assert an equitable charge against the continuing trust interest of a beneficiary does not mean that the trustee has an equitable, rather than a legal, claim for payment from other funds.

4. *Alternative Remedies.*

The general unavailability of equitable relief for claims like petitioners' cannot be circumvented by saying that equitable relief was available where legal remedies were not. US Br. 26. To bring within Section 502(a)(3) any remedy that equity *could* provide, even if it did so only "sometimes" (Pet. Br. 21, citing Dobbs (1993), § 3.1 at 279-80), is to adopt the very test *Mertens* rejected over a vigorous dissent. More particularly, it would simply reverse the congressional rejection of a damages remedy under Section 502(a)(3), as established by

Mertens, if the unavailability of damages elsewhere formed the basis for bringing the same relief within Section 502(a)(3).

In a similar vein, petitioners suggest that, unless their suit is deemed one for "equitable relief," ERISA plans would lack a remedy to enforce rights of recovery. Pet. Br. 29; *see id.* at 36. As explained in Argument II, Part C, *infra*, the premise of this argument has not remotely been established. Beyond that, however, this argument runs squarely into *Mertens*. This Court there established the standard circumscribing the reach of "equitable relief," despite the evident consequence that some harms would go unredressed by restricting remedies to only a subset of the full range of remedies that the legal system, through its various courts, has traditionally found needed. *See Reich*, 33 F.3d at 757 (*Mertens* "strips the pension funds, or . . . their surrogate the Department of Labor, of their principal remedy—a suit for damages"). In fact, given the scope of preemption under ERISA and the carefully limited remedies provided by ERISA itself, it is well accepted that those injured in the normal course of plan administration—including injured in non-monetary ways—will sometimes lack corrective remedies. *E.g.*, *Bast v. Prudential Ins. Co.*, 150 F.3d 1003 (9th Cir. 1998) (wrongful death from delayed authorization for treatment); *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996) (wrongful death from delayed authorization for treatment); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (suicide resulting from refusal to authorize psychiatric benefits under the plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993) (wrongful death from withdrawn authorization for surgery); *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir. 1993) (wrongful death from delayed authorization for surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (wrongful death of unborn child from denial of authorization for hospitalization); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991) (wrongful death).

D. Petitioners Cannot Rely On Federal Common Law

Petitioners argue that federal common law can supplement Section 502(a)(3) if that section does not afford them the relief they seek. Pet. Br. 32-37. This argument must be rejected for multiple reasons. *First*, petitioners did not present any such question in their petition for certiorari, which was entirely about the scope of Section 502(a)(3). Pet. i, 10. *Second*, petitioners made no such contention in the court of appeals, in which, as in their certiorari petition, they argued only for coverage by Section 502(a)(3). C.A. Brief for Appellants 16-31. *Third*, this Court has made clear that carefully crafted statutory regimes are not to be supplemented by judicial creation of additional federal common law remedies. *See Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1 (1981); *Milwaukee v. Illinois*, 451 U.S. 304 (1981). Such supplementing of statutory remedies is quite different from judicially developing legal principles *under* statutory directives, as when "develop[ing] a 'federal common law of rights and obligations under ERISA-regulated plans'" in the course of adjudicating the ERISA cases actually authorized by Section 502. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989), quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

II. IF PETITIONERS' CLAIM IS FOR EQUITABLE RELIEF, IT IS NEVERTHELESS NOT FOR APPROPRIATE EQUITABLE RELIEF

Even if the Court concludes that petitioners' suit seeks "equitable relief," the suit should nevertheless fail under Section 502(a)(3)'s additional requirement that the suit be for "appropriate" equitable relief. Petitioners' suit does not seek

"appropriate" relief. Rather, it pursues its remedy through a duplicative proceeding harmful to ERISA and other recognized interests without a demonstrated need to bear such harms.

A. Section 502(a)(3) Requires That Any Equitable Relief Be Appropriate, Considering More Than Just Its Responsiveness To The Asserted Wrong

The language of Section 502(a)(3) requires not only that a plaintiff's claim be for "equitable relief," but also that the relief sought be "appropriate." 29 U.S.C. § 1132(a)(3). This Court confirmed in *Varity Corp.* that appropriateness, as the statutory language indicates, is a second requirement for inclusion within Section 502(a)(3): in a case where the relief before the Court (an order of reinstatement in a benefit plan) was unquestionably equitable (*see* 516 U.S. at 495), the Court separately stressed that "the statute authorizes '*appropriate*' equitable relief" (*id.* at 515) (emphasis in original). If (as hereafter assumed) petitioners' claim for relief is deemed to be "equitable," it nevertheless should be held not appropriate, hence outside Section 502(a)(3) for that distinct reason.

In determining whether a claim for relief, even if "equitable," is "appropriate," it is relevant to consider more than simply whether the relief would redress the asserted wrong. The Court has made clear that one such consideration is whether other avenues are available to protect the legitimate interests of the plan participants. *Varity Corp.*, 516 U.S. at 515 (citing *Russell*, 473 U.S. at 144). The Court has also made clear that it is relevant, too, whether allowing pursuit of the claim would conflict with ERISA policy, as would needlessly increasing litigation expenses, to the detriment of beneficiaries as well as plans. *See id.* at 497 (avoiding high "litigation expenses" is a congressional purpose). It should also be relevant whether allowing the suit presents the sort of substantial potential for friction between

federal and state courts that, in various other contexts, has weighed against federal courts exercising authority they might otherwise have.[23] Those principles, while often articulated in "abstention" settings, have a natural place in determining what relief is "appropriate."

B. Recognizing Reimbursement Claims Under Section 502(a)(3) Would Authorize Harmful Duplicative State And Federal Court Litigation

The interpretation of Section 502(a)(3) urged by petitioners would inherently lead to the very difficulties that, at least unless shown to be unavoidable, should render the suits authorized by that interpretation not "appropriate." In particular, the proposed interpretation automatically authorizes duplicative litigation, with a federal court ERISA action intrinsically related to and overlapping with the underlying state-court tort suit (which cannot be made to disappear). It makes no sense to generate the resulting

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[23] *See, e.g., Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 717-18 (1996), quoting *Railroad Comm'n of Tex. v. Pullman Co.*, 312 U.S. 496, 500-01 (1941) ("'history of equity jurisdiction is the history of regard for public consequences,'" including prominently "'the avoidance of needless friction with state policies'" or state courts); *Wilton v. Seven Falls Co.*, 515 U.S. 277 (1995) (abstention in light of state proceeding considers factors, such as "the assumption by either court of jurisdiction over a res, the relative convenience of the fora, avoidance of piecemeal litigation, the order in which jurisdiction was obtained by the concurrent fora, whether and to what extent federal law provides the rules of decision on the merits, and the adequacy of state proceedings"); *see also* Dobbs (1993), § 2.5 at 123 ("equitable relief may be denied . . . for reasons of convenience or policy, as where enforcement of an injunction . . . might interfere with resolution of the case by other courts, agencies or departments"); *Ruhrgas AG v. Marathon Oil Co.*, 526 U.S. 574, 586 (1999) ("Cooperation and comity, not competition and conflict, are essential to the federal design."); *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982) ("courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction" (internal quotation marks omitted)).

increase of litigation costs and of occasions for federal-court-caused disruption of state-court proceedings where, as shown in the next point, petititioners have not demonstrated that ERISA plans are unable to protect their interests by participating in the state-court suit.

Except for claims by injured persons settled without even filing a tort suit (which is not the case here), the suit petitioners would have this Court authorize will always be a second suit associated with the underlying tort suit. The tort suit will typically be in state court, and nothing about the federal court proceeding will terminate the state court case. Petitioners' view of Section 502(a)(3) is thus a prescription for regular duplicative litigation, one case in federal court and the other closely related case in state court.

Such duplicative litigation adds expense, as the parties must appear in a new forum, familiarize a new judge with the issues, and ensure coordination of the proceedings. The added costs must be borne by the beneficiary or participant and by the plan itself. Furthermore, the federal court proceedings may delay or even prevent the completion of the state court proceedings that generate the recovery sought by the plan in the first place. Again, not only may the injured beneficiary suffer, but the plan itself may lose as well.

Separating matters that are interrelated, as petitioners propose, creates obvious difficulties of coordination and potential for state-federal conflict. The federal court may be asked, as it was here, to issue an injunction against the state court proceedings. JA 95. Those state proceedings, in turn, may involve various determinations based on the state court's distinctive familiarity with the relevant evidence, *e.g.*, about the reasonableness of the allocation to various types of damages of amounts recovered either in settlement or by judgment. There may be multiple claimants to the same pool of money, perhaps multiple liens (such as those of Medi-Cal or the attorneys), perhaps priority contests. The creation of a

new legal entity like a Special Needs Trust through a probate proceeding may be involved. A decedent's estate in probate may be involved. It makes little sense, in terms of judicial efficiency and comity, to strip out the reimbursement issue from the state-court proceeding and create two proceedings where the same *res*, the recovery amount, is in play.[24]

The ERISA plan may even be a party to the state court cases. Commonly, such plans have a subrogation right along with the reimbursement right, as petitioners asserted they had here. *See* JA 71, 77; US Br. 25 n.17; *cf.* 5 U.S.C. §§ 8131, 8132 (subrogation and reimburse-ment right of United States when injured employee recovers for medical expenses paid by United States). The two are naturally related, in that the subrogation right gives the plan the ability to step in and try to maximize the recovery by suing the alleged tortfeasor itself, if it believes that the injured beneficiary is not doing so. It is not disputed that the ERISA plan itself, as subrogee, would have to pursue the tort suit in state court, often alongside the injured beneficiary as a co-plaintiff: the subrogee simply "stands in the insured's shoes against the third-party tortfeasor" in whole or in part (US Br. 25 n.17) and pursues the claim.[25] It makes little sense to permit the

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[24] For such reasons, the Court has recognized the special ability of bankruptcy, probate, or other *in rem* proceedings to generate final dispositions of property to foreclose the interests of those who may not actually have been parties (at least if they had notice). *See Richards v. Jefferson County*, 517 U.S. 793, 799 (1996); *Martin v. Wilks*, 490 U.S. 755, 762 n.2 (1989).

[25] A subrogee steps into the place of the subrogor, with whatever rights the subrogor had. *See United States v. California*, 507 U.S. at 756; *Reliance Nat. Indemn. Co. v. General Star Indem. Co.*, 72 Cal. App. 4th 1063, 1078 (2d Dist. 1999). It follows that what is acquired—the tort claim itself—remains legal (under state law rules) if it was legal (and based on state law) in the first place. *See* 58 Cal. Jur. 3d Subrogation § 31 at 680. ERISA does not transform the tort claim into a federal law claim under ERISA. *See, e.g., American & Foreign Ins. Co. v. Bolt*, 106 F.3d

ERISA plan, after litigating the case in state court to generate a recovery, to file a separate federal-court suit to litigate the distribution of the same money. And it makes little sense for any rule under Section 502(a)(3) to treat reimbursement and subrogation differently: the source of the money sought is the same, and an ERISA plan can be written to include either one.

C. Petitioners Have Not Shown The Duplicative Litigation To Be Necessary To Protect Plan Interests

The inherent costs accompanying petitioners' view of Section 502(a)(3)—costs to beneficiaries, to the federal and state judiciaries, and to plans—should not be authorized in the absence of a showing that they are unavoidable. It need not be questioned that ERISA-covered plans have a legitimate interest in securing recovery, out of alleged tortfeasors' payments to an injured beneficiary, of money spent on her medical care. Petitioners, however, have not come close to showing that ERISA plans cannot protect their interests by resort to state-court mechanisms, avoiding duplicative litigation.

An ERISA plan can write its provisions to state clearly the recovery to which it is entitled and (like this one) to give itself a lien on recoveries. An ERISA plan also can write a subrogation right, entitling it, upon paying a beneficiary's medical claims, to step into her shoes as a plaintiff (alone or with her) in suing the alleged tortfeasor in state court. Indeed, according to Great-West itself, in both its letter to Eric Knudson and the Right of Recovery Agreement that it drafted, the Plan in this case already had the right to participate in the state-court action, as a subrogee of the claim

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155 (6th Cir. 1997) (subrogee action as jury action); *Cigna Ins. Co. v. Oy Saunatec, Ltd.*, 241 F.3d 1 (1st Cir. 2001) (same); *Granite State Ins. Co. v. Smart Modular Technologies, Inc.*, 76 F.3d 1023 (9th Cir. 1996) (same).

against Hyundai or otherwise. JA 71, 77. Petitioners have never disputed that, at a minimum, California procedural law permitted them to intervene in respondent's suit against Hyundai, whether before or after the conditional settlement was reached, to assert their interests and demand the share to which they were entitled of the recovery amount within the jurisdiction of the state court. *See* JA 238.[26]

Petitioners argue, however, that state-law relief is preempted, citing in support only one decision, that of a California intermediate appellate court in a case not involving a comparable proceeding. Pet. Br. 29-30, quoting *Jefferson-Pilot Life Ins. Co. v. Krafka*, 50 Cal. App. 4th 190 (2d Dist. 1996) (state law contract cause of action for a money judgment preempted; no issue of enforcement of a lien in state court or assertion of a claim against an alleged tortfeasor as subrogee). For its part, the United States carefully refrains even from asserting that "a cause of action . . . under state law to enforce a reimbursement term of a plan" would be preempted; instead, it says only that it "*presumably*" or "*likely*" would be, without further discussion of the ways in which plan rights might be asserted. US Br. 20 (emphases added).

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[26] *See* Cal. Code Civ. Pro. § 387 (intervention); *Olszewski v. ScrippsHealth*, 107 Cal. Rptr. 2d 187, 206 n.17 (4th Dist. 2001); *Plut v. Fireman's Fund Ins. Co.*, 102 Cal. Rptr. 2d 36, 40 (Ct. App. 2d Dist. 2000) ("'the insurer's safest course in order to preserve its subrogation rights is to seek intervention in the underlying action' brought by the insured against the legally responsible party"); *Donohue v. Highlands Underwriters Ins. Co.*, 198 Cal. App. 3d 1176, 1181 (1st Dist. 1988); 39 Cal. Jur. 3d (Rev.) Insurance Contracts § 653 at 517-18 (insurer may intervene or directly sue alleged tortfeasor). For federal court analogs, see, *e.g.*, 7C C. Wright, A. Miller, & M. Kane, *Federal Practice & Procedure* § 1908 at 272, 274-75 (1986) (intervention); 6A *id.* § 1546 at 362 (1990) (intervention or joinder); *United States v. Aetna Cas. & Sur. Co.*, 338 U.S. 366 (1949); *Counihan*, 194 F.3d at 361-62; *Ghazarian v. Wheeler*, 177 F.R.D. 482, 485-86 (C.D. Cal. 1997).

In fact, the decisions of this Court do not require preemption of state-court proceedings to determine rights in a recovery from third parties. A state law may be preempted if it has "reference to" ERISA plans, *i.e.*, if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). But general state law allowing intervention to assert liens on recovery amounts in the litigation, or to adjudicate a subrogee's state-law claim in conjunction with the subrogor's, plainly does not fall within that class. The inquiry therefore is whether such state law has "a connection with" ERISA plans, the second branch of preemption. *Id.*

Under *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and its successors, the determination of such a "connection" begins with "the normal presumption against pre-emption" (*De Buono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806, 813 (1997)) and focuses on any practical conflict with ERISA policy, based on "'the objectives of the ERISA statute'" and "the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325; *see Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001). Preemption has been found in two circumstances (*see Travelers*, 514 U.S. at 658): where state law required plan choices, about benefit payments or other plan terms, different from those which might be voluntarily made [27]; and where state laws subjected

[27] *See Egelhoff*, 121 S. Ct. at 1327 (state law that "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status"); *Boggs v. Boggs*, 520 U.S. 833 (1997) (state law permitting transfer of pension benefits to person other than plan-designated person); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (state law barring adoption of subrogation provision); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state law requiring minimum mental-health benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (state law prohibiting

plans to remedial liabilities beyond those Congress authorized.[28] Preemption has thus turned on inconsistency with plan choices or with congressional choices about the scope of liabilities. The Court has stated that "[t]he basic thrust of the pre-emption clause" is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans" (*Travelers*, 514 U.S. at 657) and thus has focused on whether types of state laws subject plans to "'conflicting directives'" (*id.* at 662). *See Eglehoff*, 121 S. Ct. at 1328; *FMC Corp. v. Holliday*, 498 U.S. 52, 59-60 (1990); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11 (1987); *see also Egelhoff*, 121 S. Ct. at 1330 (suggesting that state laws that are well-established, with long pre-ERISA history, and "more or less uniform nationwide," whose "interference with the aims of ERISA" is questionable, might not be preempted); *Dillingham*, 519 U.S. at 332 n.10..

The state-court mechanisms for plans to enforce reimbursement rights do not involve the circumstances that have led to holdings of preemption. The state court, in such proceedings, must follow the terms of the ERISA plan as chosen by its sponsors, and as construed in light of relevant federal law principles; there is no interference with plan drafters' or administrators' choices. Nor is there imposition of any additional liability on plans or, for that matter, on beneficiaries or participants. Indeed, such state-law

certain plan benefits choices as discriminatory); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (state law barring reduction of plan benefits by amount of workers' compensation award).

[28] *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (state-law claim seeking extracontractual damages); *Pilot Life, supra* (same); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (in addition to express preemption of state cause of action as one having "reference to" ERISA plan, also finding conflict preemption, where in fact plaintiff was seeking extracontractual damages, 498 U.S. at 481, subsequently held unavailable under ERISA § 502(a)(3) in *Mertens*).

proceedings offer remedies *for* plans, giving them exactly what they are entitled to receive. Most pointedly, if (contrary to Argument I above) the relief the Plan seeks is "equitable," there is no basis for saying that Congress "rejected" the relief that a state court would afford the Plan, namely, its share of the state-court recovery as determined according to the terms of the plan. *Pilot Life*, 481 U.S. at 54.

If petitioners cannot complain about the relief they would get, or the rights on which the relief would be based, they equally cannot charge that preemption would unify proceedings in federal court or allow a more uniform administration without need for individualized decision-making. The underlying state-court tort case remains; it cannot be transferred to federal court, even if the plan participates as subrogee; and the plan must monitor the individual case regardless of its ability to proceed in federal court, making case-specific judgments about that case and what the Plan may, or should, demand. Any interest in preemption, therefore, can only come down to the abstract concern that particular state courts might come to different interpretations of ERISA plans than would particular federal courts—though federal courts themselves may disagree and, here, the state and federal courts actually agreed about the meaning of petitioners' plan terms. But there is no basis for denigrating the ability or readiness of state courts to remain faithful to the terms of ERISA plans and any federal-law interpretive principles. And ERISA policy is affirmatively advanced by keeping litigation costs down and not interfering with the resolution of state court cases that produce the recoveries that plans seek in the first place.

The absence of preemption of the state-court proceedings at issue is reinforced by this Court's upholding of state-court enforcement mechanisms in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988). The Court there held that ERISA does not preempt the application to

ERISA-governed plans of general state-law processes, in state court, for garnishing plan benefits, ruling broadly that "state-law methods for collecting money judgments," including federal court judgments, are simply outside the scope of Section 502, yet plainly contemplated by Congress to be available, and thus "must, as a general matter, remain undisturbed by ERISA." *Id.* at 833-34. The Court explained particularly that the garnishment process at issue, which involved an order of a state court (*see id.* at 828), was a "'procedural' mechanism" only, "creat[ing] no substantive causes of action, no new bases for relief, or any grounds for recovery"—all of which would be matters of federal law where federal law supplied the basis for the garnishment, as when the judgment being enforced (in state court) was a federal-court judgment. *Id.* at 834 n.10. *See Peacock v. Thomas*, 516 U.S. 349, 353 (1996) (citing *Mackey*); *Travelers*, 514 U.S. at 662 (same).

The neutral state-court mechanisms for enforcing a plan lien or subrogation right likewise do not depend on creation of a new substantive cause of action or new basis for relief or ground for recovery. *Mackey*, 486 U.S. at 834 n.10.[29] In that context, preemption would work to undermine, not protect, the interests of ERISA participants, beneficiaries, and plans. Petitioners, who did not attempt to participate in the state court proceeding to test any speculation about preemption, have not shown that ERISA preempts the state-court

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[29] A lien-enforcement mechanism does not involve *in personam* liability at all, but is an *in rem* procedure. On the distinction in various contexts, see, *e.g.*, *Johnson v. Home State Bank*, 501 U.S. 78, 84 (1991) ("a bankruptcy discharge extinguishes only one mode of enforcing a claim—namely, an action against the debtor *in personam*—while leaving intact another—namely, an action against the debtor *in rem*"); *United States v. Rodgers*, 461 U.S. 677, 694-95 (1983) (tax lien enforcement); *California v. Deep Sea Research, Inc.*, 523 U.S. 491, 501 (1998) (admiralty); *Mercy Hosp. & Medical Ctr. v. Farmers Ins. Group*, 15 Cal.4th 213, 217 (1997).

mechanisms that are distinctly preferable in terms of ERISA policy and otherwise. With no basis for concluding that the various costs of a separate federal action under Section 502(a)(3) need to be borne, that action, even if "equitable," should be found not "appropriate" and thus held outside the scope of Section 502(a)(3).

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

RICHARD G. TARANTO
Counsel of Record
FARR & TARANTO
1220 19th Street, NW
Washington, DC 20036
(202) 775-0184

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